THE HEALTH CARE FINANCING ADMINISTRATION (HCFA)
Medicare Part A Specification for the ANSI ASC X12 837 Implementation Guide [Claims]

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Introduction

The Health Care Financing Administration (HCFA) has adopted the American National Standards Institute, Accredited Standards Committee (ASC) X12.86 Health Care Claim (ANSI 837) as the standard format for the electronic data interchange (EDI) of Medicare claim data for Medicare services.

A. Purpose of this Implementation Guide

This implementation guide is intended to provide assistance in the development and execution of the electronic transfer of claim data. All specifications in this document conform to ANSI ASC X12.86 standards, adopted for use by Medicare Part A. These specification are designed to be compatible with currently existing communications networks.

B. Scope and Applicability

The purpose of these standards is to expedite HCFA's goal of achieving a totally paperless claims processing and payment environment. The ANSI X12 standards are formulated to minimize the need for users to reprogram their data processing systems for multiple formats by allowing data interchange through the use of a common interchange structure. These standards do not define the method in which interchange partners should establish the required electronic media communication link, nor the hardware and translation software requirements to exchange EDI data. Each intermediary must provide these specific requirements separately. This document does not address the specific requirements of non-Medicare payers.

SUMMARY OF CHANGES FROM 3A.00 TO 3A.01

Position/Segment	Description of Revision
CR8	deleted
NA	Mappings have been updated for the UB-92 version 5.0
BGN	Updated map for BGN03
1-015-REF	Updated REF02 for 3A.01
2-005-PRV	Updated map for PRV03
2-130-CLM	Updated example
2-135.A-DTP	Updated DTP01 - DTP03
2-135.B-DTP	Updated segment
2-135.D-DTP	New
2-135.E-DTP	New
2-135.F-DTP	New
2-135.G-DTP	New

2-135.H-DTP	New
2-135.I-DTP	New
2-135.J-DTP	New
2-135.K-DTP	New
2-180-REF	Updated map for REF02
2-180.AA-REF	New - INVESTIGATIONAL DEVICE EXEMPTION NUMBER
2-180.B REF	Updated example
2-190.B-NTE	Updated NTE01 (see UB-92 specifications for codes)
2-216-CR6	Updated dates and mappings
2-220.A-CRC	Updated map for CRC03 (Functional Limitations)
2-220.B-CRC	Updated map for CRC03 (Activities Permitted)
2-220.C-CRC	Updated map for CRC03 (Mental Status)
2-225.B-HI	Updated dates and mapping (Procedure Codes)
2-225.C-HI	Updated dates and mapping (Occurrence Codes)
2-225.D-HI	Updated dates and mapping (Occurrence Span Codes)
2-225.F-HI	Updated example
2-244-HSD	Updated mapping
2-250.A-NM1	Updated map for NM103 - NM105 (Attending Physician)
2-270-N4	Updated map for N403
2-250.B-NM1	Updated map for NM103 - NM105 (Operating Physician)
2-250.D-NM1	Deleted (Ordering Physician)
2-285-SBR	Updated map for SBR08
2-325.E-NM1	New - Contract Number
2-350-DTP	Updated map for DTP02 and DTP03
2-395-SV2	Updated mapping
2-475-DTP	Updated

BACKGROUND

A. Electronic Data Interchange (EDI)

EDI is the acronym for Electronic Data Interchange. EDI is the exchange of information on routine business transactions in a standardized computer format; for example, data interchange between a Medicare Intermediary and a provider. EDI originated when a number of industries desired to save costs and reduce waste through the electronic transmission of business information. They were convinced that in this computerized world, standardization of formatted information was the most effective means of communicating with multiple trading partners.

EDI offers several advantages. In addition to standardized formats that can be used with multiple trading partners, technology now allows anyone with a computer and a modem to participate in EDI. With EDI, there is a substantial reduction in handling and processing time, and the risk of lost paper documents is eliminated.

As with any new technology, there are costs associated with EDI. These costs are likely to be similar to those incurred in any decision to automate. However, new issues that may have to be evaluated for the first time with EDI are translation software and the cost of connectivity to a Value Added Network (VAN).

B. ANSI and ASC X12

The American National Standards Institute (ANSI) coordinates voluntary standards in the United States. Many standards developers and participants support ANSI as the central body responsible for the identification of a single consistent set of voluntary standards called American National Standards.

ANSI provides an open forum for all concerned interests to identify specific business needs, plan to meet those needs, and agree on standards. ANSI itself does not develop standards. ANSI approval of standards indicates that the principles of openness and due process have been followed in the approval procedures and that a consensus of those materially affected by the standards has been achieved.

In 1979, ANSI chartered a new committee, known as Accredited Standards Committee (ASC) X12, Electronic Data Interchange, to develop uniform standards for electronic interchange of business transactions. The work of ASC X12 is conducted primarily by a series of subcommittees and task groups whose major function is the development of new, and the maintenance of existing, EDI standards.

Currently, ASC X12 has more than 600 voluntary members. Membership is open to virtually all organizations and individuals with a material interest in the standards. Benefits include an opportunity to vote on every issue before the

X12 committee and frequent information updates on committee activities and standards. The insurance subcommittee of ASC X12 includes representatives from health care payers, providers, provider associations, banks, software vendors and government agencies (Medicare, Medicaid, etc.). More information about ANSI, ASC X12, and the standards development process appears in "An Introduction to Electronic Data Interchange" (Section G).

C. HCFA Use of X12 Standards

In the near future, X12 standards are anticipated to be the national norm for electronic transmission of health care data. As part of HCFA's continuing commitment to achieve administrative savings through the use of electronic claim processing options, including the decision to migrate to financial EDI, HCFA has become a member of the X12 committee. HCFA's active participation in X12 is expected to accelerate the acceptance of specific electronic standards throughout the health care industry.

HCFA is now committed to develop both claim and remittance advice formats according to X12 standards for use by Medicare Fiscal Intermediaries (FIs) and Carriers. A version of the ANSI Health Care Claim Payment/ Remittance advice (835) has been offered by FIs since October 1992. An 835 for Carriers, as well as a Health Care Claim (837) for both FIs and Carriers will be implemented on October 1, 1993.

D. Implementation Guide Changes

As an aid to the initial implementation for Intermediaries, Section B provides a map of the UB92 data elements to the elements' locations on the 837. However, due to factors like the differences between variable and fixed-length records, the map cannot provide one-to-one correspondence.

The implementation is specific to the Medicare Part A program, and has been developed within the standard for the ANSI ASC X12.86 transaction, version 003051. All future changes to this implementation guide will remain within the requirements of X12.86. Implementation guide updates will continue to be released through HCFA. ASC X12 subcommittees and task groups continue to develop and maintain EDI standards. To meet legislative and regulatory requirements, HCFA will participate with X12 to revise the standards. Scheduled maintenance is planned to occur annually.

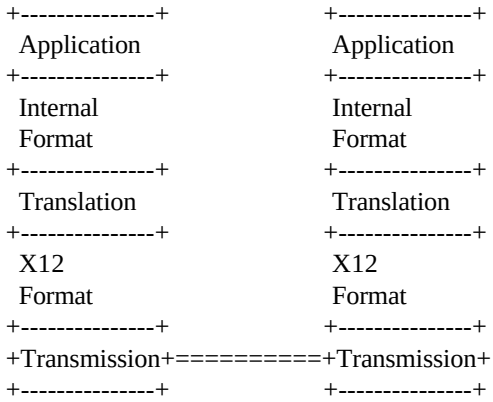
Important EDI Concepts

The insurance subcommittee health care task group (X12N-TG2) has developed, under the guidelines of ANSI ASC X12, several standards for the interchange of health care information between providers, payers and trading partners. EDI standards facilitate the exchange of information between different computers by providing a standard communication mechanism applicable to any computer system, and by conveying the information required for the processing of claims, payments, enrollments, eligibility, and other common business functions in health care.

These EDI standards have been designed for efficiency in the electronic data interchange. They have not been designed as a standard way to solve the business needs of processing the data for adjudication or account balancing. Such functions are intrinsic to the trading partners that exchange the information, and therefore beyond the scope of the standards.

When a computer application communicates data to a different computer, the data must first be generated in an internal format, and then sent to the receiving computer in a standard format that both computers will understand. Finally, the receiving computer must convert the received data into an internal format for application processing.

Using common layer diagrams, this process would be represented as:



Before the advent of industry standards, the common format would be unique to each pair of computer applications. With the introduction of X12 standards, the same format can be used between multiple trading partners. Further, the process of "translating" internal data format to and from the X12 EDI format can be done by general purpose "translation software". The X12 EDI formatted data could be invisible to the applications, but visible to the translation software. The applications would only see their internal data format.

The translator software could be written in-house or purchased commercially Most commercial translators are table-driven and they can be used to convert to and from numerous types of data or "transactions" with multiple business applications. Once a translator is installed, the same software can translate data between X12 formats and selected internal flat file formats, in either direction; for instance, to translate outgoing health insurance claims as well as incoming remittance advices.

With the recent explosion of EDI applications, the vendors of translation software have produced a wide variety of offerings, ranging from inexpensive PC-based packages to sophisticated mainframe-based translators that handle mailboxing, queues, and multiple versions of the standards simultaneously. Another important point is the degree to which the translator can be changed and updated with ease and flexibility whenever there is a new release of the standard.

One alternative to translators is to let a Value Added Network (VAN) or Clearinghouse do the translation. This option is generally more cost effective for smaller volume sites, or in cases where the initial investment in the required translation software may not be advisable.

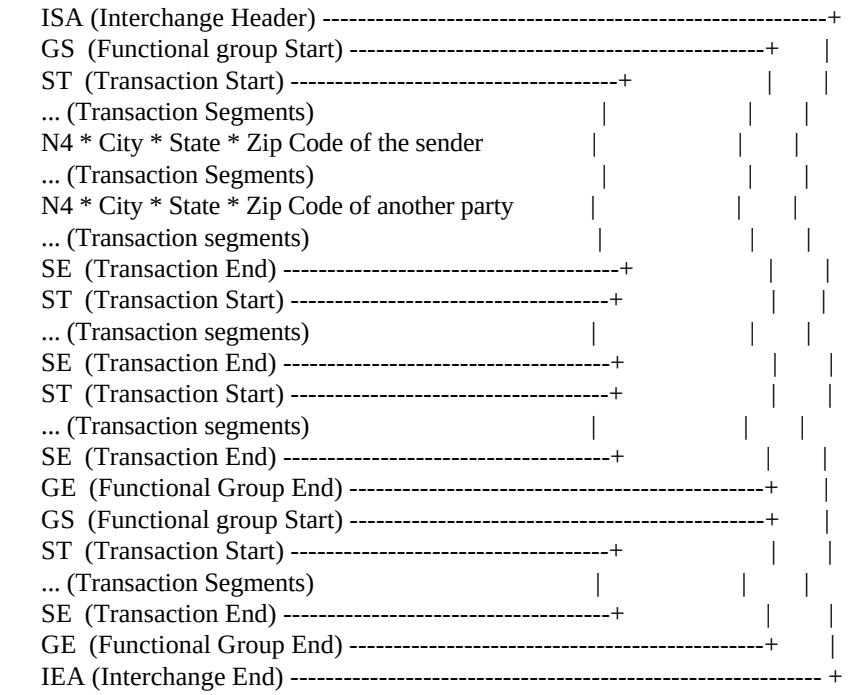
A. Interchange Overview

The transmission of data proceeds according to very strict format rules in order to insure the integrity and maintain the efficiency of the interchange. Each business grouping of data is called a "transaction". For instance, a group of health insurance claims sent from one provider to a Medicare Intermediary or a remittance advice returned by that Intermediary could each be considered a transaction.

Each transaction contains groups of logically related data in units called "segments". For instance, the "N4" segment used in the transaction conveys the city, state, zip code, and other geographic information. A transaction contains multiple segments, so the addresses of the different parties, for example, can be conveyed from one computer to the other. Using an analogy, the transaction would be like a freight train, the segments would be the train's cars, and each segment could contain several data "elements" the same as a train car can hold multiple crates.

The sequence of the elements within one segment is specified by the ASC X12N standard, as well as the sequence of segments in the transaction. In a more conventional computing environment, the segments would be equivalent to "records", and the elements equivalent to "fields".

Similar transactions, called "functional groups", are sent together within a transmission. Each functional group is prefaced by a "group start" segment, and a functional group is terminated by a "group end" segment. One or more functional groups are prefaced by an "interchange header", and followed by an "interchange trailer". This is illustrated below:



The interchange header and trailer segments envelope one or more functional groups or interchange-related control segments and perform the following functions:

Define the data element separators and the data segment terminators,
Identify the sender and receiver,
Provide control information for the interchange, and
Allow for authorization and security information.

B. Interchange Control Structure Definitions and Concepts

Basic Structure

A data element corresponds to a data field in data processing terminology. It is the smallest named item in the X12 standard. A control segment has the same structure as a data segment; the distinction is in the usage. The data segment is used primarily to convey user information while the control segment is used primarily to convey control information and for grouping data segments. A data segment corresponds to a record in data processing terminology. The data segment begins with a segment ID and contains related data elements. Other definitions, such as data element types, may be found in ANSI ASC X12.6 Application Control Structure.

Implementation Considerations

This section covers implementation considerations, including the character sets used in the interchange of the transaction sets, with particular emphasis on the delimiters. The basic and extended character sets are defined in X12.6; reference should be made to that standard for a definition of those character sets. Portions of those definitions are repeated here as required for understanding during the implementation.

1 Basic Character Set

The selection that follows is designed to have representation in the common character code schemes of EBCDIC, ASCII, and CCITT International Alphabet 5. The ASC X12 standards are graphic-character-oriented; therefore, common character encoding schemes other than those specified herein my be used as long as a common mapping is available. Since the graphic characters have an implied mapping across character code schemes, those bit patterns are not provided here.

The basic character set of this standard includes those selected from the uppercase letters, digits, space, and special characters as specified below.

A...Z 0...9 "!" """ "&" "," "(" ")" "*" "+"

"," "-" "." "/" ":" ";" "?" "=" " " (Space)

2 Extended Character Set

An extended character set may be used by negotiation between the two parties and includes the lowercase letters and other special characters as specified below.

a...z "%" "~" "@" "[" "]" "_" "{" "}"

"\" "" "<" ">" "#" "$"

It should be noted that the extended characters include several character codes that have multiple graphical representations for a specific bit pattern. The complete list appears in other standards such as CCITT S.5. Use of the U.S.A. graphics for these codes presents no problem unless data is

exchanged with an international partner. Other problems, such as the translation of item descriptions from English to French, arise when exchanging data with an international partner, but minimizing the use of codes with multiple graphics eliminates one of the more obvious problems.

3 Control Characters

Two control character groups are specified; they have only restricted usage. The common notation for these groups is also provided, together with the character coding in three common alphabets. In the following table IA5 represents CCITT V.3 International Alphabet 5.

3.1 Base Control Set

The base control set includes those that will not have a disruptive effect on most communication protocols. These are represented by:

Notation	EBCDIC	ASCII	IA5
BEL bell	2F	07	07
HT horizontal tab	05	09	09
LF line feed	25	OA	OA
VT vertical tab	OB	OB	OB
FF form feed	OC	OC	OC
CR carriage return	OD	OD	OD
FS file separator	1C	1C	1C
GS group separator	1D	1D	1D
RS record separator	1E	1E	1E

The Group Separator (GS) may be an exception in this set, since it is used in the 3780 communications protocol to indicate blank space compression.

3.2 Extended Control Set

The extended control set includes those that may have an effect on a transmission system. These are represented by:

Notation	EBCDIC	ASCII	IA5
SOH start of header	01	01	01
STX start of text	02	02	02
ETX end of text	03	03	03
EOT end of transmission	37	04	04
ENQ enquiry	2D	05	05
ACK acknowledge	2E	06	06
DC1 device control 1	11	11	11
DC2 device control 2	12	12	12
DC3 device control 3	13	13	13

DC4 device control 4	3C	14	14
NAK negative acknowledge	3D	15	15
SYN synchronous idle	32	16	16
ETB end of block	26	17	17

4 Delimiters

A delimiter is a character used to separate two data elements (or subelements) or to terminate a segment. The delimiters are an integral part of the data.

Delimiters are specified in the interchange header and are not to be used in a data element value elsewhere in the interchange. During the development of EDI, the historically preferred delimiters have been the asterisk as the data element separator and the new line character as the segment terminator. These two delimiters can be visualized on the printed page and display each segment on a separate line, adding human readability to the transaction set.

Due to potential conflicts with either the data elements or with the special needs of transmission and device control, the historically used delimiters have caused problems. The following recommendations are provided for the delimiter character selection. These recommendations are in decreasing order of preference as indicated below.

Data Element Separator & Subelement Separator

Preferred	Acceptable	Should not be used
>	control_char	uppercase_letter
	extend_control_char	digit
	* (Asterisk)	lower_case_letter
	(Vertical Bar)	special_char
	> (Greater Than)	
	~ (Tilde)	
	^ (Circumflex)	

Terminator

Preferred	Acceptable	Should not be used
FS	control_char	uppercase_letter
~	extend_control_char	digit
	(Vertical Bar)	lower_case_letter
	~ (Tilde)	special_char
	^ (Circumflex)	

These recommendations are made for the following reasons. The carriage return (CR) and line feed (LF) are usually used as a special device control characters. The new line character does not have a clear mapping between character sets. The asterisk has potential for conflict within the data; however, it is used in our examples for readability. The uppercase_letter, digit, and lower_case_letter have too high a chance of conflict with the data. Many of the special_char may also appear in the data. The problem with many of the characters in control_char and extend_control_char is that they have either special device control characteristics or are used for transmission control.

It is recommended that you select data element (and subelement) separators that and a segment terminator that are not part of the business data, do not conflict

with the communication protocol and are printable characters in order to make error resolution easier.

C. Business Transaction Structure
Definitions and Concepts

Basic Structure

The X12 standards define commonly used business transactions in a formal, structured manner called transaction sets. A transaction set is composed of a transaction set header control segment, one or more data segments, and a transaction set trailer control segment. Each segment is composed of: a unique segment ID; one or more logically related simple data elements or composite data structures, or both, each preceded by a data element separator; and a segment terminator.

Composite data structures are composed of one or more logically related component data elements, each, except the last, followed by a component element separator. The data segment directory entry referenced by the data segment ID defines the sequence of simple data elements and composite data structures in the segment and any interdependencies that may exist. The composite data structure directory entry referenced by the composite data structure number defines the sequence of component data elements in the composite data structure.

A data element in the transaction set header identifies the type of transaction set. A functional group contains one or more related transaction sets preceded by a functional group header control segment and terminated by a functional group trailer control segment.

Delimiters

The delimiters consist of two levels of separators and a terminator. The delimiters are an integral part of the transferred data stream. Delimiters are specified in the interchange header and are not to be used in a data element value elsewhere in the interchange with the exception of their possible appearance in the binary data element.

Data Element

The data element is the smallest named unit of information in the X12 standard. Data elements are identified as either simple or component. A data element that occurs as an ordinally positioned member of a composite data structure is identified as a component data element. A data element that occurs in a segment outside the defined boundaries of a composite data structure is identified as a simple data element. The distinction between simple and component data elements is strictly a matter of context since a data element can be used in either capacity.

Numeric

A numeric is represented by one or more digits with an optional leading sign representing a value in the normal base of 10. The value of a numeric data element includes an implied decimal point. It is used when the position of the decimal point within the data is permanently fixed and is not to be transmitted with the data.

The data element dictionary defines the number of implied decimal positions. The representation for this data element type is "Nn" where N indicates that it is numeric and n indicates the number of decimal positions to the right of the implied decimal point.

If n is 0, it need not appear in the specification; N is equivalent to N0. For negative values, the leading minus sign (-) is used. Absence of a sign indicates a positive value. The plus sign (+) should not be transmitted.

Leading zeros should be suppressed unless necessary to satisfy a minimum length requirement. The length of a numeric type data element does not include the optional sign.

FOR EXAMPLE: Value is "-123.4". Numeric type is N2 where the "2" indicates an implied decimal placement two positions from the right. The data stream value is "-12340". The length is 5 (note padded zero)

Decimal Number

A decimal data element contains an explicit decimal point and is used for numeric values that have a varying number of decimal positions. The representation for this data element type is "R."

The decimal point always appears in the character stream if the decimal point is at any place other than the right end. If the value is an integer (decimal point at the right end) the decimal point should be omitted. For negative values, the leading minus sign (-) is used. Absence of a sign indicates a positive value. The plus sign (+) should not be transmitted.

Leading zeros should be suppressed unless necessary to satisfy a minimum length requirement. Trailing zeros following the decimal point should be suppressed unless necessary to indicate precision. The use of triad separators (for example, the commas in 1,000,000) is expressly prohibited. The length of a decimal type data element does not include the optional leading sign or decimal point.

Identifier

An identifier data element always contains a value from a predefined list of values that is maintained by the X12 Committee or some other body recognized by the X12 Committee. Trailing spaces should be suppressed unless necessary to satisfy minimum length. The representation for this data element type is "ID."

String

A string data element is a sequence of any characters from the basic or extended character sets. The significant characters shall be left justified and shall be space filled. Leading spaces, when they occur, are presumed to be significant characters. Trailing spaces should be suppressed unless they are necessary to satisfy minimum length. The representation for this data element type is "AN."

Date

A data element is used to express the ISO standard date in YYMMDD format in which YY is the year in the century (00 to 99), MM is the month (01 to 12), and DD is the day in the month (01 to 31). The representation for this data element type is "DT."

Time

A time data element is used to express the ISO standard time HHMMSSd..d format in which HH is the hour for a 24 hour clock (00 to 23), MM is the minute (00 to 59), SS is the second (00 to 59) and d..d is decimal seconds. The representation for this data element type is "TM."

Data Element Reference Number

Data elements are assigned a unique reference number to locate them in the data dictionary. For each data element, the dictionary specifies the name, description, type, minimum length, and maximum length. For ID data elements, the dictionary lists all code values and their descriptions or references where the valid code list can be obtained.

Data Element Type

The following types of data elements appear in the dictionary.

Type	Symbol
Numeric	Nn
Decimal	R
Identifier	ID
String	AN
Date	DT
Time	TM

Data Element Length

Each data element is assigned a minimum and maximum length. The length of the data element value is the number of character positions used except as noted for numeric, decimal, and binary elements.

Data Segment

The data segment is an intermediate unit of information in a transaction set. In the data stream, a data segment consists of a segment identifier, one or more composite data structures or simple data elements each preceded by a data element separator, and a segment terminator. Data segments are defined in the "implementation detail" in Section IV. This subsection defines each segment including the segment's name, purpose, and identifier, and the composite data structures and/or data elements that it contains.

Data Segment Identifier

Each data segment has a unique two- or three-position identifier. This identifier serves as a label for the data segment.

Data Elements in a Segment

In defining a segment, each simple data element or composite data structure within the data segment is further characterized by a reference designator and a data element reference number or composite data structure reference identifier. Simple data elements and composite data elements may have additional attributes, including a condition designator and a semantic note designator.

Reference Designator

Each simple data element or composite data structure in a segment is provided a structured code that indicates the segment in which it is used and the sequential position within the segment. The code is composed of the segment identifier followed by a two-digit number that defines the position of the simple data element or composite data structure in that segment. For purposes of creating reference designators, the composite data structure is viewed as the hierarchical equal of the simple data element. Each component data element in a composite data structure is identified by a suffix appended to the reference designator for the composite data structure of which it is a member. This suffix is a two-digit number, prefixed with a hyphen, that defines the position of the component data element in the composite data structure. For example, the first simple element of the SVC segment would be identified as SVC01 because the position count does not include the segment identifier, which is a label. If the second position in the SVC segment were occupied by a composite data structure that contained three component data elements, the reference designator for the second component data element would be SVC02-02.

Condition Designator

Data element conditions are of three types: mandatory, optional, and relational; and define the circumstances under which a data element may be required to be present or not present in a particular segment.

Mandatory Condition

The designation of mandatory is absolute in the sense that there is no dependency on other data elements. This designation may apply to either simple data elements or composite data structures. Mandatory conditions are specified by condition code "M".

Condition	Requirement
(M) Mandatory	The designated simple data element or composite data structure must be present in the segment (presence means a data element or composite structure must not be empty). If the designation applies to a composite data structure, then at least one value of a component data element in that composite data structure shall be included in the data segment.

Optional Condition

The designation of optional means that there is no requirement for a simple data element or composite data structure to be present in the segment. Optional conditions are specified by condition code "O".

Condition	Requirement
(O) Optional	The presence of a value for a simple data element or the presence of value for any of the component data elements of a composite data structure is at the option of the sender.

Relational Conditions

Relational conditions may exist among two or more simple data elements within the same data segment based on the presence or absence of one of those data elements (presence means a data element must not be empty). Relational conditions are specified by a condition code and the identity of the subject elements. A data element may be subject to more than one relational condition.

The definitions for each of the <condition_code> values are:

Condition	Requirement
(P) Paired or Multiple	If any element specified in the relational condition is present, then all of the elements specified must be present.
(R) Required	At least one of the elements specified in the condition must be present.
(E) Exclusion	Not more than one of the elements specified in the condition may be present.

© Conditional — If the first element specified in the condition is present, then all other elements must be present. However, any or all of the elements NOT specified as the FIRST element in the condition may appear without requiring that the first element be present. The order of the elements in the condition does not have to be the same as the order of the data elements in the data segment.

(L) List Conditional — If the first element specified in the condition, then at least one of the remaining elements must be present. However, any or all of the elements NOT specified as the FIRST element in the condition may appear without requiring that the first element be present. The order of the elements in the condition does not have to be the same as the order of the data elements in the data segment.

Semantic Note Designator

Simple data elements or composite data structures may have a designation that indicates the existence of a semantic note. A semantic note provides important additional information regarding the intended meaning of a designated data element, particularly a generic type, in the context of its use within a specific data segment. Semantic notes may also define a relational condition among data elements in a segment based on the presence of a specific value (or one of a set of values) in one of the data elements. Semantic notes are considered part of the relevant transaction set standard.

Semantic Note (Z)

A semantic note is referenced in the segment directory for this data element with respect to its use in this data segment.

Absence of Data

Any simple data element that is indicated as mandatory must not be empty if the segment is used. At least one component data element of a composite data structure that is indicated as mandatory must not be empty if the segment is used. Optional simple data elements and/or composite data structures and their preceding data element separators that are not needed should be omitted if they occur at the end of a segment. If they do not occur at the end of the segment, the simple data element values and/or composite data structure values may be omitted. Their absence is indicated by the occurrence of their preceding data element separators, in order to maintain the element's or structure's position as defined in the data segment.

Transaction Set

The transaction set is the smallest meaningful set of information exchanged between trading partners. The transaction set consists of a transaction set headers segment, one or more data segments in a specified order, and a transaction set trailer segment.

Transaction Set Header and Trailer

The transaction set header and trailer segments are constructed as follows:

Transaction Set Header (ST)
Data Segment Group
Transaction Set Trailer (SE)

The transaction set identifier, uniquely identifies the transaction set. This identifier is the first data element of the transaction set header segment. The value for the transaction set control number, in the header and trailer control segments must be identical for any given transaction. The value for the number of included segments, is the total number of segments in the transaction set including the ST and SE segments.

Data Segment Groups

The data segments in a transaction set may be repeated as individual data segments or as unbounded or bounded loops.

Repeated Occurrences of Single Data Segments

When a single data segment is allowed to be repeated, it may have a specified maximum number of occurrences defined at each specified position within a given transaction set standard. Alternatively, a segment may be allowed to repeat an unlimited number of times. The notation for an unlimited number of repetitions is ">1".

Loops of Data Segments

Loops are groups of semantically related segments. Data segment loops may be unbounded or bounded.

Unbounded Loops

In order to establish the iteration of a loop, the first data segment in the loop shall appear once and only once in each iteration. Loops may have a specified maximum number of repetitions. Alternatively, the loop may be specified as having an unlimited number of iterations. The notation for an unlimited number of repetitions ">1".

There is a specified sequence of segments in the loop. Loops themselves are optional or mandatory. The requirement designator of the beginning segment of

a loop indicates whether at least one occurrence of the loop is required. Each appearance of the beginning segment defines an occurrence of the loop.

The requirement designator of any segment within the loop after the beginning segment applies to that segment for each occurrence of the loop. If there is a mandatory requirement designator for any data segment within the loop after the beginning segment, that data segment is mandatory for each occurrence of the loop.

If unbounded loops are nested within loops, the inner loop shall not start at the same ordinal position as any outer loop. The inner loop shall not start with the same segment as its immediate outer loop. For any segment that occurs in a loop and in the parent structure of that loop, that segment must occur prior to that loop in the parent structure or subsequent to an intervening mandatory segment in the parent structure (parent structure is composed of all segments at the same level of nesting as the beginning segment of the loop).

Bounded Loops

The characteristics of unbounded loops described previously also apply to bounded loops. In addition, bounded loops require a loop start (LS) segment to appear before the first occurrence and a loop end (LE) segment to appear after the last occurrence of the loop. If the loop does not occur, the LS and LE segments shall be suppressed. The requirement designator on the LS and LE segments must match the requirement designator of the beginning segment of the loop.

A bounded loop may contain only one loop structure at the level bracketed by the LS and LE segments. Subordinate loops are permissible. If bounded loops are nested within loops, the inner loop shall not start at the same ordinal position as any outer loop. The inner loop must end before or on the same segment as its immediate outer loop.

Data Segments in a Transaction Set

When data segments are combined to form a transaction set, three characteristics are to be applied to a data segment in that usage: a requirement designator, a position in the transaction set, and a maximum occurrence.

Data Segment Requirement Designators

A data segment shall have one of the following requirement designators indicating its appearance in the data stream of a transmission. These requirement designators are represented by a single character code.

Designator Requirement

(M) Mandatory This data segment must be included in the transaction set.
(Note that a data segment may be mandatory in a loop of data segments, but the loop itself is optional if the beginning segment of the loop is designated as optional.)

(O) Optional The presence of this data segment is the option of the sending party.

(F) Floating This is used only for the NTE segment that may appear anywhere in the transaction set between the transaction set header and the transaction set trailer. Its use is not recommended.

Data Segment Position
The ordinal positions of the segments in a transaction set are explicitly specified for that transaction. Subject to the flexibility provided by the optional and floating requirement designators of the segments, this positioning must be maintained.

Data Segment Occurrence
A data segment may have a maximum occurrence of one, or a finite number greater than one, or an unlimited number.

Functional Group

A functional group is a group of similar transaction sets that is bounded by a functional group header segment and a functional group trailer segment. The functional identifier defines the group of transactions that may be included within the functional group. The value for the functional group control number, in the header and trailer control segments must be identical for any given group. The value for the number of included transaction sets, is the total number of transaction sets in the group.

Control Segment

A control segment has the same structure as a data segment but is used for transferring control information rather than application information.

Loop Control Segments

Loop control segments are used only to delineate bounded loops. Delineation of the loop shall consist of the loop header (LS segment) and the loop trailer (LE segment). The loop header defines the start of a structure that must contain one or more iterations of a loop of data segments and provides the loop identifier for this loop. The loop trailer defines the end of the structure. The LS segment appears only before the first occurrence of the loop, and the LE segment appears only after the last occurrence of the loop.

Transaction Set Control Segments

The transaction set is delineated by the transaction set header (ST segment) and the transaction set trailer (SE segment). The transaction set header identifies the start and identifier of the transaction set. The transaction set trailer defines the end of the transaction set and provides a count of the data segments, which includes the ST and SE segments.

Functional Group Control Segments

The functional group is delineated by the functional group header (GS segment) and the functional group trailer (GE segment). The functional group header starts and identifies one or more related transaction sets and provides a control number and application identification information. The functional group trailer defines the end of the functional group of related transaction sets and provides a count of contained transaction sets.

Relations among Control Segments

The control segments of this standard must have a nested relationship as is shown and annotated in this subsection. The letters preceding the control segment name are the segment identifier for that control segment. The indentation of segment identifiers shown below indicates the subordination among control segments.

GS Functional Group Header, starts a group of related transaction sets.
ST Transaction Set Header, starts a transaction set.
LS Loop Header, starts a bounded loop of data segments but is not part of the loop.
LS Loop Header, starts an inner, nested, bounded loop.
LE Loop Trailer, ends an inner, nested, bounded loop.
LE Loop Trailer, ends a bounded loop of data segments but is not part of the loop.
SE Transaction Set Trailer, ends a transaction set.
GE Functional Group Trailer, ends a group of related transaction sets.

More than one ST/SE pair, each representing a transaction set, may be used within one functional group. Also more than one LS/LE pair, each representing a bounded loop, may be used within one transaction set.

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A. Introduction to the 837

This section provides information for the actual use of the 837 For Intermediaries to transfer Medicare Part A Claim information from a provider electronically.

This implementation is based upon the X12 Standards Draft Version 3 Release 3, Subrelease 2, published in June of 1993. A copy of the standards document is available through:

Data Interchange Standards Association, Inc.
1800 Diagonal Road, Suite 355
Alexandria, Virginia 22314-2852
(703) 548-7005

B. Medicare A 837 Implementation Guide Organization and Use

UB92

The Employment Status Code Indicator (21 Record) will appear in the Ref Segment of the 2330 loop. A new qualifier code "ZZ", identifies the Ref Segment as the Employee Status Code Indicator. Please note this qualifier code is not included in version 30.51 of the standard and must be added.

Segment Sequence Numbers

The 837 Standard contains numeric references for the positions of various segments within the transaction. This document also uses numeric position identifiers, however, these may not exactly match those found in the ASC X12 837 transaction documentation. This section will specify multiple uses of a particular segment exactly. Each iteration of the segment will be shown with its own numeric reference.

Element Reference Numbers

In the Implementation Summary, the "Ele#" column will provide the ASC X12 data element reference number for your convenience. This will facilitate cross referencing with the X12 Documentation.

Medicare 837 Data Types

The 837 transaction uses multiple data types. These data types are referenced in the Implementation Summary, and are defined as follows:

AN Alpha-numeric (string) - any printable character, with the exception of the data element and segment separators. Significant characters must be left justified. Trailing spaces must be suppressed, unless required to meet minimum length specifications.

ID Identifier - An identifier data type must contain a value from a list maintained by ASC X12 or another specified external body. The applicable values for usage in the Medicare Part A implementation are provided in the Implementation Summary.

DT Date - The format for the Date data type is YYMMDD.

Nn	Numeric - The numeric data type is symbolized by an "N" followed by a single numeric character. The numeric character, symbolized by the "n" identifies the number of positions to the right of the implied decimal point. The number is identified to be positive, unless an explicit leading minus sign is used to indicate a negative number. The minimum and maximum lengths of the numeric character are calculated without counting the minus sign.
R	Decimal - This data type is used to represent numeric data where the decimal point is not preset. Integer values are sent without a decimal point. The decimal point is required for fractional values. The number is identified to be positive, unless accompanied by a leading minus sign. The minus sign and decimal point are not counted when determining the length of the number. Leading zeroes or plus sign are suppressed.
TM	Time - The Time data type is express in 24 hour clock format, HHMMSSd..d. "d..d" represents the numeric expression of decimal seconds.

Please reference section III for a complete description of data types.

Data Element and Segment Separators

The ASC X12 standards allow for the usage of various characters as delimiters. The actual delimiters used in any specific interchange are determined in the envelope, specifically within the ISA segment. The ISA segment consists of all mandatory data elements, with fixed data length, i.e. the minimum and maximum are identical. The data element separator and segment terminator used in the ISA determines the characters used throughout the entire data interchange defined by that ISA and its corresponding trailer segment, the IEA.

In the balance of the implementation guide, the "*" is shown as the data element separator and the "~" is shown as the segment terminator. This has been done for simplicity, and should not be construed as the preferred approach. Please reference Section III for a detailed description of delimiters and the recommended usage for Medicare Part A and the 837.

Functional Acknowledgments

The Medicare Part A implementation of the 837 will utilize the X12 Functional Acknowledgement capability. The submitter may request an acknowledgement response in ISA14, in which case the Intermediary will respond with a 997 Functional Acknowledgement. The intermediary must respond within one business day after the day of receipt. The submitter must not acknowledge the receipt of the 997 back to the intermediary, thus avoiding an endless loop of acknowledgements to acknowledgements.

837 Philosophy

The vision of HCFA is to enable all participants in the health care community to benefit from the administrative cost savings that can be achieved from the adoption of national, non-proprietary electronic data interchange (EDI) formats. As part of HCFA's efforts to evolve Medicare into a paperless environment HCFA has committed to using national standard formats for all of HCFA's electronic transmission between contractors and the provider community. In keeping with this commitment, HCFA has decided to adhere to the ANSI formats.

Currently, there are about 400 formats for electronic claims being used in the United States. Reducing that number to one ANSI structure will greatly decrease the burden on health care providers and their billing services.

HCFA believes that the standardization of data content for administrative formats is vital to the growth of EDI in the health care industry.

ANSI Formats--

ANSI formats are non-proprietary in application. HCFA has recognized the benefits that can be derived from the adoption of a national non-proprietary EDI format for health care claims transactions. The adoption of the 837 format allows for communicating business transactions with a large number of trading partners. It also allows for providers to operate more efficiently.

Standardization of content improves communication for all trading partners. Greater uniformity can significantly reduce administrative complexities.

The ANSI ASC X12 architecture is very flexible. New data segments and codes may be added with minimal technical difficulty. The variable length record also accommodates changes easier than fixed length records.

The 837 is a variable-length record designed for wire transmission and is not suitable for use in an application program. Therefore, the UB-92 flat-file must be translated into the 837 format for transmission from providers or their billing services to the receiving processor, which must then translate the 837 into a flat-file for applications system processing. Each sender and receiver must agree on the blocking factor and/or other pertinent telecommunication protocols.

Medicare Part A 837 General Information--

The Medicare Part A Specifications for the 837 implementation guide stipulate the exact contents required to submit a Medicare electronic claim by mapping the HCFA UB-92 flat-file to the 837. The cost of converting to the 837 should not be significant since the mapping constitutes half of the work involved in writing a translator.

Implementation Guide Format--

HCFA's implementation guide was designed to provide all technical information required for each segment in one section. This avoids having to move to other sections to obtain data element number, attributes, etc. The following describes how to read the implementation tables and detail.

Implementation Set: The Implementation Set is an overview of the entire 837 transaction as used in the Medicare Part A implementation guide. The columns and their contents are described below.

TABLE 2

Nte Pos.	Seg. Name	Req.	Max.Use	Loop Repeat
	Loop ID - 2000 [1]			
N 005	PRV Billing Provider	M	1	1000
[3] [4]	[5]	[6]	[7] [8]	[2]

where:

[1] Identifies the loop in which the related segments are grouped

[2] The number of times the loop can be repeated

[3] Notes follow the table specifying relational conditions, general explanation, etc.

[4] Unique identifier that serves as a label for the segment.

[5] The official ANSI ASC X12 acronym for each segment used in the 837.

[6] The name of each segment used in the Medicare Part A implementation of the 837.

[7] Req. stands for requirement designator, and gives a letter indication the requirement status for each segment: M = Mandatory, O = Optional, C = Conditional. N is not really a requirement status, but instead stands for "not used," which means this particular segment is not used for Medicare Part A implementation of the ANSI ASC X12 837 transaction set.

[8] Max. Use gives the maximum number of times each segment can be used in an 837. Most of these entries are 1 or greater than (>) 1.

Implementation Summary: The Implementation Summary contains more specific information than the implementation set. The columns and their contents are described below.

TABLE 2

Positn.	Seg+E	Requirement	Segment & Element Name	Ele#	Attributes
		Begin Loop [1]	2000 [2]		Max. Use:1000
005 [3]	PRV [4]	Mandatory [5]	Billing Provider [6]		Max. Use:1 [7]
	PRV01 [8]	Mandatory	Provider Code [9]	1221 [10]	"BI" [11]

where:

[1] Identifies the loop in which the related segments are grouped

[2] The number of times the loop can be repeated

[3] Unique identifier that serves as a label for the segment

[4] Segment Identifier

[5] Requirement Designator

[6] Segment name

[7] The number of time the segment is allowed to be repeated

[8] Data element reference designator

[9] Data element name

[10] X12 data element number provides the ANSI ASC X12 official reference number for your convenience. This will facilitate cross-referencing with the X12 documentation.

[11] The 837 transaction uses multiple data types. These data types are references in the Implementation Summary, and are defined as follows:

AN Alpha-numeric (string) - any printable character, with the exception of the data element and segment separators. Significant characters must be left justified. Trailing spaces should be suppressed.

ID Identifier - An identifier data type must contain a value from a list maintained by ASC X12 or another specified external body. The applicable values for usage in the Medicare Part A implementation are provided in the Implementation Summary.

DT Date - The format for the Date data type is YYMMDD.

NO Numeric - The numeric data type is symbolized by an "N" followed by a single numeric character. The numeric character, symbolized by the "n" identifies the number of positions to the right of the implied decimal point. The number is identified to be positive unless an explicit leading minus sign is used to indicate a negative number. The minimum and maximum lengths of the numeric character are calculated without counting the minus sign.

R Decimal - This data type is used to represent numeric data where the decimal point is not present. Integer values are sent without a decimal point. The decimal point is required for fractional values. The number is identified to be positive, unless accompanied by a leading minus sign. The minus sign and decimal point are not counted when determining the length of the number. Leading zeroes or plus signs are suppressed.

TM Time - The Time data type is expressed in a 24 hour clock format, HHMMSSd..d. "d..d" represents the numeric expression of decimal seconds.

Note: Please reference section III for a complete description of data types. Note that, when permitted by the program the guide is written in, cases in which there is only one entry possible for Medicare Part A are hard coded into the data type. Such entries appear in boldface with quotation marks around them.

Implementation Detail: The Implementation Detail reiterates and supplements information contained in the Implementation Set and Summary. The columns and their contents are described below.

Medicare A 837 Health Care Claim 2-005-PRV [1]
==========

X12 Segment Name: PRV Provider Information
Name: Billing Provider
Loop: 2000
Max. Use: 1
X12 Purpose: To specify the identifying characteristics of a provider
Usage: Mandatory
Example: PRV*BI*1C*IM0345~
Comments: The Billing Provider is assumed to also be the Rendering Provider for all service lines of all claims, unless overridden in loop 2310 or 2420 by a NM101 containing code 82

Syntax Note: P0505 - If either PRV05 or PRV06 is present, then the other must be present.

Semantic Note: PRV05 qualifies PRV06.

Element Attributes	Data Element Usage	UB92
PRV01 1221	Provider Code	[3]
ID 1 3 M	[2] Code identifying the type of provider	
	Codes:	
	BI Billing	[4]
PRV02 0128	Reference Number Qualifier	
ID 2 2 M	Code qualifying the Reference Number	
	Codes:	
	1C Medicare Provider Number	
PRV03 0127	Reference Number	10-06 [5]
AN 1 30 M	Provider Medicare Number	30-24

Reference number or identification number as defined for a particular Transaction set, or as specified by the Reference Number Qualifier. The number assigned to the provider by [6] the Medicare payor for Medicare identification purposes. where: [1] Identifies the Table (2), the unique identifier for the segment (005), and the segment identifier (PRV)

[2] Element Attributes, where: PRV01 is the data element reference designator
1221 is the X12 data element dictionary reference #
ID is the data element type
1 is the minimum data element length
3 is the maximum data element length
M is the requirement designator

[3] Data element name
[4] Code definition and explanation
[5] A map, when existing, from each 837 element to a UB92 field. If there is no map to the UB92 there is no entry in this column. However the phrase "translator generated" appears for fields that are created by translators. Section B also contains a complete map from the UB92 to the 837 along with further descriptions of the mapping conventions used in this guide.
[6] Medicare specific requirements will appear here (beneath ANSI). In many cases Medicare requirements are more specific that those of X12. Medicare requirements not shared by X12 will appear in boldface.

The Medicare Part A 837 Defined

1. About this section

The Implementation Set, Summary and Detail presented in this section form the core of the 837 implementation guide for Intermediaries. They represent a national standard. Intermediaries and their providers must follow these instructions when implementing the 837 for use in the Medicare Part A Program. No part of this text is to be modified without the knowledge and consent of HCFA.

Medicare requirements are more specific than those of X12 in many cases. The program in which this guide is written is specifically designed to highlight gradations of requirements between X12 and HCFA meaning that HCFA requires providers to use a specific code, for Medicare billing, selected from a list of possible X12 codes. Requirements of the Medicare program appear in boldface in Section IV. Boldface text should not be altered in any way by intermediaries or providers. Medicare requirements presented in boldface may represent a range of HCFA decisions, including standing Medicare policies or HCFA-imposed selections of ANSI codes made to limit code choices to those appropriate to Medicare Part A.

NOTE: Since Medicare A claims processing is predicated on the UB-92 data content and field lengths, Medicare contractors will accept the maximum ANSI field lengths but will only process the maximum UB-92 field lengths.

If you have any comments regarding the implementation guide, please fax them to (410) 966-7488, attention Matt Klischer.

837 Health Care Claim

This Draft Standard for Trial Use contains the format and establishes the data contents of the Health Care Claim Transaction Set (837) for use within the context of an Electronic Data Interchange (EDI) environment. This standard can be used to submit health care claim billing information from providers of health care services to payers, either directly or via intermediary billers and claims clearinghouses. It can also be used to transmit health care claims and billing payment information between payers with different payment responsibilities where coordination of benefits is required. For purposes of this standard, providers of health care products or services may include entities such as physicians, hospitals and other medical facilities or suppliers, dentists, and pharmacies. The payer refers to a third party entity that pays claims or administers the insurance product or benefit or both. For example, a payer may be an insurance company, health maintenance organization (HMO), preferred provider organization (PPO), government agency (Medicare, Medicaid, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), etc.) or an entity such as a third party administrator (TPA) or third party organization (TPO) that may be contracted by one of those groups.

For purposes of this implementation guide the Max.Use has been restricted to Medicare A requirements, and most loops and some segments have been replicated in order to better reflect the actual Medicare A implementation. Refer to the X12.86 standard for a more succinct representation of the 837 transaction set.

TABLE 0

Nte	Pos.	Seg.	Name	Req.	Max.Use	Loop Repeat
	010	ISA	Interchange Control Header	M	1	
	020	GS	Functional Group Header	M	1	

TABLE 1

Nte	Pos.	Seg.	Name	Req.	Max.Use	Loop Repeat
	005	ST	Transaction Set Header	M	1	
	010	BGN	Beginning Segment	M	1	
	015	REF	Version Number	M	1	
			LOOP ID - 1000			1 0
N	020	NM1	Submitter Name and ID	M	1	
	025	N2	Additional Submitter Name	O	1	
	030	N3	Submitter Address	O	1	
	035	N4	Submitter City, State, ZIP	O	1	
	040	REF	-	N	1	
	045	PER	Submitter Contact	O	1	

TABLE 2

Nte Pos.	Seg.	Name	Req.	Max.Use	Loop Repeat
		LOOP ID - 2000			1000
N 005	PRV	Billing Provider	M	1	
007	DTP	-	N	1	
010	CUR	-	N	1	
		LOOP ID - 2010			1
N 015	NM1	Billing Provider Name and ID	C	1	
020	N2	Billing provider Additional Name	O	1	
025	N3	Billing Provider Address	O	1	
030	N4	Billing Provider City, State, ZIP	O	1	
035	REF	-	N	1	
040	PER	Billing Provider Telephone Number	O	1	
		LOOP ID - 2100			99999
N 045	SBR	Medicare Primary / Secondary / Terti	M	1	
050	DTP	-	N	1	
		LOOP ID - 2110			1
N 055	NM1	-	N	1	
060	N2	-	N	1	
065	N3	-	N	1	
070	N4	-	N	1	
075	DMG	-	N	1	
080	PER	-	N	1	
085	REF	-	N	1	
		LOOP ID - 2200			1
090	PAT	Patient Information	M	1	
091	DTP	-	N	1	
		LOOP ID - 2210			1
N 095	NM1	Patient Name and HICNO	M	1	
100	N2	-	N	1	
105	N3	Patient Address	M	1	
110	N4	Patient City, State, ZIP	M	1	
115	DMG	Patient Demographic Information	M	1	
120	PER	-	N	1	
125	REF	Medical Record Number	O	1	

		LOOP ID - 2300			100
130	CLM	Health Claim	M	1	
135.A	DTP	Statement Covers Period	C	1	
135.B	DTP	Admission Date	C	2	
135.C	DTP	Discharge Date/Hour	O	2	
140	CL1	Claim Codes	C	1	
175.A	AMT	Patient Amount Paid	O	1	
175.B	AMT	Patient Balance Due	O	1	
180.A	REF	Original ICN/DCN Number	O	1	
180.AA	REF	Invest. Device Exemption #	O	1	
180.B	REF	Data ID	O	1	
190.A	NTE	Billing Remarks	O	20	
190.B	NTE	Home Health Corresp Data	O	20	
216	CR6	Home Health Care Certification	O	1	
220.A	CRC	Home Health Funct Limitations	O	3	
220.B	CRC	Home Health Activ Permitted	O	3	
220.C	CRC	Home Health Mental Status	O	3	
225.A	HI	Health Care Information Codes	O	25	
225.B	HI	Health Care Information Codes	O	25	
225.C	HI	Health Care Information Codes	O	25	
225.D	HI	Health Care Information Codes	O	25	
225.E	HI	Health Care Information Codes	O	25	
225.F	HI	Health Care Information Codes	O	25	
225.G	HI	Health Care Information Codes	O	25	
240.A	QTY	Covered Days Actual	C	1	
240.B	QTY	Non-Covered Days Actual	O	1	
240.C	QTY	Co-Insurance Days Actual	O	1	
240.D	QTY	Lifetime Reserve Days Actual	O	1	
241	HCP	-	N	1	
		LOOP ID - 2305			6
243	CR7	Home Health Treat Plan Cert	O	1	
244	HSD	Health Care Services Delivery	O	12	
245	LS	Loop Header	O	1	
		LOOP ID - 2310.A			9

N 250.A	NM1	Attending Physician Name	M	1	
255.A	PRV	-	N	1	
260.A	N2	-	N	1	
265.A	N3	-	N	1	
270.A	N4	Patient City, State, ZIP	O	1	
271.A	REF	-	N	1	
275.A	PER	-	N	1	
		LOOP ID - 2310.B			9
N 250.B	NM1	Operating Physician Name	O	1	
		LOOP ID - 2310.C			9
N 250.C	NM1	Other Physician Name	O	1	
280	LE	Loop Trailer	O	1	
281	LS	Loop Header	O	1	
		LOOP ID - 2320			10
285	SBR	Additional Payor Information	C	1	
290	CAS	-	N	1	
300.A	AMT	Payor Amount Paid	O	15	
300.B	AMT	Estimated Amount Due	O	15	
305	DMG	Other Ins Birthdate and Sex	C	1	
310	OI	Supp Payor Type of Insurance	C	1	

	LOOP ID - 2330				10
325.A	NM1	Supp Payor Name	C	1	
355.AA	REF	Treatment Authorization Number	O	3	
355.AB	REF	Provider Identification Number	O	3	
355.AC	REF	Original ICN/DCN Number	O	3	
325.B	NM1	Other Insured Name	C	1	
330.B	N2	-	N	2	
335.B	N3	Other Insured Address	O	2	
340.B	N4	Other Insured City, State, ZIP	O	1	
325.C	NM1	Subscriber's Employer Name	C	1	
335.C	N3	Subscriber's Employer Address	O	2	
340.C	N4	Subsc Employer City, State, Zip	O	1	
325.D	NM1	Other Employer Name	C	1	
335.D	N3	Other Employer Address	O	2	
340.D	N4	Other Employer City, State, ZIP	O	1	
355.D	REF	Employment Status Code	O	3	
325.E	NM1	Contract Number	C	1	
365	LE	Loop Trailer	O	1	
	LOOP ID - 2400				10000
N 385	LX	Assigned Number	M	1	
390	SV1	-	N	1	
395	SV2	Institutional Service	M	1	
400	SV3	-	N	1	
401	TOO	-	N	1	
405	SV4	-	N	1	
420	SV5	-	N	1	
425	SV6	-	N	1	
430	SV7	-	N	1	
435	HI	-	N	25	
440	PWK	-	N	1	
N 445	CR1	-	N	1	
450	CR2	-	N	1	
455	CR3	-	N	1	
460	CR4	-	N	1	
465	CR5	-	N	1	
470	CRC	-	N	3	
475	DTP	Outpatient Service Date	C	1	
480	QTY	-	N	1	
481	MEA	-	N	1	
485	CN1	-	N	1	
490	REF	-	N	1	
495	AMT	-	N	1	

500	K3 -	N	1		
505	NTE -	N	4		
510	PS1 -	N	1		
511	HCP -	N	1		
	LOOP ID - 2410			10	
N 512	LIN -	N	1		
514	CTP -	N	1		
515	LS -	N	1		
	LOOP ID - 2420			1	
N 520	NM1 -	N	1		
550	LE -	N	1		
	LOOP ID - 2430			1	
N 556	SVD -	N	1		
557	CAS -	N	99		
558	DTP -	N	1		
560	SE Transaction Set Trailer	M	1		

TABLE 4

Nte	Pos.	Seg.	Name	Req.	Max.Use	Loop Repeat
	010	GE	Functional Group Trailer	M	1	
	020	IEA	Interchange Control Trailer	M	1	

Table 1 Position 020 Note 1: Loop 1000 contains submitter and receiver information. If any intermediary receivers change or add data in any way, then they add an occurrence to the loop as a form of identification. The added loop occurrence must be the last occurrence of the loop.

Table 2 Position 005 Note 1: See Figures Appendix for a detail structure of Table 2 of the 837 Transaction Set.

Table 2 Position 015 Note 1: Loop 2010 contains provider information: Billing Provider Information, Pay-To Provider

Table 2 Position 045 Note 1: Loop 2100 contains information about the subscriber of the current insurance carrier.

Table 2 Position 055 Note 1: Loop 2110 contains name and address information for: Subscriber, Subscriber's Current Insurance Carrier, Subscriber's School or Employer

Table 2 Position 095 Note 1: Loop 2210 contains name and address information for: Patient, Patient's Legal Representative, Party Responsible for the Patient

Table 2 Position 195 Note 1: The CR1 through CR5 and CRC certification segments appear on both the claim level and the service line level because certifications can be submitted for all services on a claim or for individual services. Certification information at the claim level applies to all service lines of the claim, unless overridden by certification information at the service line level.

Table 2 Position 250 Note 1: The information in this loop will apply to all service lines of the claim, unless overridden by information at the service line level.

Table 2 Position 285 Note 1: Loop 2400 contains Service Line information.

Table 2 Position 310 Note 1: Loop 2410 contains compound drug components, quantities and prices.

Table 2 Position 345 Note 1: The CR1 through CR5 and CRC certification segments appear on both the claim level and the service line level because certifications can be submitted for all services on a claim or for individual services. Certification information at the claim level applies to all service lines of the claim, unless overridden by certification information at the service line level.

Table 2 Position 420 Note 1: The information in this loop overrides the information in the claim-level segments if the entity identifier codes in each NM1 segment are the same.

Table 2 Position 460 Note 1: Loop 2500 contains insurance information about: Paying and Other Insurance Carriers for that Subscriber, Subscriber of the Other Insurance Carriers, School or Employer Information for that Subscriber

Table 2 Position 460 Note 2: Segments NM1 - N4 contain name and address information of the insurance carriers referenced in the above note.

TABLE 0

Positn.	Seg+E	Requirement	Segment & Element Name	Ele#	Attributes
010	ISA	Mandatory	Interchange Control Header	Max. Use:	1
	ISA01	Mandatory	Authorization Information Qualifier	I01	ID 2 2
	ISA02	Mandatory	Authorization Information	I02	AN 10 10
	ISA03	Mandatory	Security Information Qualifier	I03	ID 2 2
	ISA04	Mandatory	Security Information	I04	AN 10 10
	ISA05	Mandatory	Interchange ID Qualifier	I05	"ZZ"
	ISA06	Mandatory	Transmission Submitter Identification	I06	AN 15 15
	ISA07	Mandatory	Interchange ID Qualifier	I05	"ZZ"
	ISA08	Mandatory	Intermediary Identification Number.	I07	AN 15 15
	ISA09	Mandatory	File Creation Date	I08	DT 6 6
	ISA10	Mandatory	File Creation Time	I09	TM 4 4
	ISA11	Mandatory	Interchange Control Standards Identi	I10	"U"
	ISA12	Mandatory	ANSI Version Code	I11	"00305"
	ISA13	Mandatory	Interchange Control Number	I12	N0 9 9
	ISA14	Mandatory	Acknowledgment Requested	I13	ID 1 1
	ISA15	Mandatory	Test Indicator	I14	ID 1 1
	ISA16	Mandatory	Component Element Separator	I15	AN 1 1
020	GS	Mandatory	Functional Group Header	Max. Use:	1
	GS01	Mandatory	Functional Identifier Code	0479	"HC"
	GS02	Mandatory	Transmission Submitter Identificatio	0142	AN 2 15
	GS03	Mandatory	Intermediary Identification Number	0124	AN 2 15
	GS04	Mandatory	Group Creation Date	0373	DT 6 6
	GS05	Mandatory	Group Creation Time	0337	TM 4 8
	GS06	Mandatory	Group Control Number	0028	N0 1 9
	GS07	Mandatory	Responsible Agency Code	0455	"X"
	GS08	Mandatory	ANSI Version Code	0480	"003051"

TABLE 1

Positn.	Seg+E	Requirement	Segment & Element Name	Ele#	Attributes
005	ST	Mandatory	Transaction Set Header	Max. Use:	1
	ST01	Mandatory	Transaction Set Identifier Code	0143	"837"
	ST02	Mandatory	Transaction Set Control Number	0329	AN 4 9
010	BGN	Mandatory	Beginning Segment	Max. Use:	1
	BGN01	Mandatory	Transaction Set Purpose Code	0353	"00"
	BGN02	Mandatory	Submission Number	0127	AN 1 30
	BGN03	Mandatory	Creation Date	0373	DT 6 6
	BGN04	Not Used			
	BGN05	Not Used			
	BGN06	Not Used			
	BGN07	Not Used			
	BGN08	Not Used			
015	REF	Mandatory	Version Number	Max. Use:	1
	REF01	Mandatory	Reference Number Qualifier	0128	"F1"
	REF02	Mandatory	Medicare A Implementation Guide Vers	0127	AN 1 30
	REF03	Not Used			
			Begin Loop 1000	Max. Use:	1
020	NM1	Mandatory	Submitter Name and ID	Max. Use:	1
	NM101	Mandatory	Entity Identifier Code	0098	"41"
	NM102	Mandatory	Entity Type Qualifier	1065	"2"
	NM103	Optional	Submitter Name	1035	AN 1 35
	NM104	Not Used			
	NM105	Not Used			
	NM106	Not Used			
	NM107	Not Used			
	NM108	Mandatory	Submitter/Biller Identification Numb	0066	"24"
	NM109	Mandatory	Submitter Identifier	0067	AN 2 20
025	N2	Optional	Additional Submitter Name	Max. Use:	1
	N201	Mandatory	Additional Submitter Name	0093	AN 1 35
	N202	Optional	Additional Submitter Name	0093	AN 1 35
030	N3	Optional	Submitter Address	Max. Use:	1
	N301	Mandatory	Submitter Address 1	0166	AN 1 35
	N302	Not Used			
035	N4	Optional	Submitter City, State, ZIP	Max. Use:	1
	N401	Optional	Submitter City	0019	AN 2 30
	N402	Optional	Submitter State	0156	ID 2 2
	N403	Optional	Submitter ZIP Code	0116	ID 3 11
	N404	Optional	Submitter Country Code	0026	ID 2 3
	N405	Not Used			
	N406	Not Used			
040	REF	Not Used			
045	PER	Optional	Submitter Contact	Max. Use:	1
	PER01	Mandatory	Contact Function Code	0366	"SM"

PER02 Mandatory Submitter Contact		0093	AN 1 35
PER03 Conditional Communication Number Qualifier	0365	"TE"	
PER04 Conditional Submitter Telephone Number	0364	AN 1 80	
PER05 Conditional Communication Number Qualifier	0365	"FX"	
PER06 Conditional Submitter Fax Number	0364	AN 1 80	
PER07 Not Used			
PER08 Not Used			
PER09 Not Used			

End Loop 1000

TABLE 2

Positn.	Seg+E	Requirement	Segment & Element Name	Ele#	Attributes
			Begin Loop 2000 Max. Use: 1000		
005	PRV	Mandatory	Billing Provider Max. Use: 1		
	PRV01	Mandatory	Provider Code	1221	"BI"
	PRV02	Mandatory	Reference Number Qualifier	0128	"1C"
	PRV03	Mandatory	Medicare Provider Number	0127	AN 1 30
	PRV04	Not Used			
	PRV05	Not Used			
	PRV06	Not Used			
	PRV07	Not Used			
007	DTP	Not Used			
010	CUR	Not Used			
			Begin Loop 2010 Max. Use: 1		
015	NM1	Conditional	Billing Provider Name and ID Max. Use: 1		
	NM101	Mandatory	Entity Identifier Code	0098	"85"
	NM102	Mandatory	Entity Type Qualifier	1065	"2"
	NM103	Mandatory	Provider Organization Name	1035	AN 1 35
	NM104	Not Used			
	NM105	Not Used			
	NM106	Not Used			
	NM107	Not Used			
	NM108	Conditional	Identification Code Qualifier	0066	"FI"
	NM109	Conditional	Billing Provider Federal Tax Number	0067	AN 2 20
020	N2	Optional	Billing provider Additional Name Max. Use: 1		
	N201	Mandatory	Billing provider Additional Name	0093	AN 1 35
	N202	Optional	Billing provider Additional Name	0093	AN 1 35
025	N3	Optional	Billing Provider Address Max. Use: 1		
	N301	Mandatory	Billing Provider Address 1	0166	AN 1 35
	N302	Not Used			
030	N4	Optional	Billing Provider City, State, ZIP Max. Use: 1		
	N401	Optional	Provider City	0019	AN 2 30
	N402	Optional	Provider State	0156	ID 2 2
	N403	Optional	Provider ZIP	0116	ID 3 11
	N404	Optional	Country Code	0026	ID 2 3
	N405	Not Used			
	N406	Not Used			
035	REF	Not Used			
040	PER	Optional	Billing Provider Telephone Number Max. Use: 1		
	PER01	Mandatory	Contact Function Code	0366	"PH"
	PER02	Optional	Billing Provider Contact Person	0093	AN 1 35
	PER03	Conditional	Communication Number Qualifier	0365	"TE"
	PER04	Conditional	Billing Provider Telephone Number	0364	AN 1 80
	PER05	Conditional	Communication Number Qualifier	0365	"FX"

```
      PER06     Conditional Billing Provider Fax Number      0364  AN   1  80
      PER07     Not Used
      PER08     Not Used
      PER09     Not Used

                End Loop 2010

                Begin Loop 2100              Max. Use:  99999

045   SBR       Mandatory   Medicare Primary / Secondary / Terti Max. Use:     1
      SBR01     Mandatory   Medicare Responsibility Sequence Cod 1138  ID   1   1
      SBR02     Not Used
      SBR03     Not Used
      SBR04     Not Used
      SBR05     Not Used
      SBR06     Not Used
      SBR07     Not Used
      SBR08     Not Used
      SBR09     Optional    Claim Filing Indicator Code          1032 "MA"
050   DTP       Not Used

                Begin Loop 2110              Max. Use:     1

055   NM1       Not Used
060   N2        Not Used
065   N3        Not Used
070   N4        Not Used
075   DMG       Not Used
080   PER       Not Used
085   REF       Not Used

                End Loop 2110

                Begin Loop 2200              Max. Use:     1

090   PAT       Mandatory   Patient Information              Max. Use:     1
      PAT01     Mandatory   Patient's Relationship to Insured    1069 "18"
      PAT02     Not Used
      PAT03     Optional    Patient Employment Status Code       0584  ID   2   2
      PAT04     Not Used
      PAT05     Not Used
      PAT06     Not Used
091   DTP       Not Used

                Begin Loop 2210              Max. Use:     1

095   NM1   Mandatory   Patient Name and HICNO              Max. Use:     1
      NM101 Mandatory   Entity Identifier Code                    0098 "QC"
```

NM102 Mandatory Entity Type Qualifier 1065 "1"
NM103 Mandatory Patient Last Name 1035 AN 1 35
NM104 Mandatory Patient First Name 1036 AN 1 25
NM105 Optional Patient Middle Initial 1037 AN 1 25
NM106 Not Used
NM107 Not Used
NM108 Mandatory Identification Code Qualifier 0066 "HN"
NM109 Mandatory Health Insurance Claim Number 0067 AN 2 20

100 N2 Not Used
105 N3 Mandatory Patient Address Max. Use: 1
N301 Mandatory Patient Address 1 0166 AN 1 35
N302 Optional Patient Address 2 0166 AN 1 35
110 N4 Mandatory Patient City, State, ZIP Max. Use: 1
N401 Mandatory Patient City 0019 AN 2 30
N402 Mandatory Patient State 0156 ID 2 2
N403 Mandatory Patient ZIP Code 0116 ID 3 11
N404 Not Used
N405 Not Used
N406 Not Used
115 DMG Mandatory Patient Demographic Information Max. Use: 1
DMG01 Mandatory Date Time Period Format Qualifier 1250 "D8"
DMG02 Mandatory Patient Date of Birth 1251 AN 1 35
DMG03 Mandatory Patient Sex Code 1068 ID 1 1
DMG04 Optional Patient Marital Status 1067 ID 1 1
DMG05 Not Used
DMG06 Not Used
DMG07 Not Used
DMG08 Not Used
120 PER Not Used
125 REF Optional Medical Record Number Max. Use: 1
REF01 Mandatory Reference Number Qualifier 0128 "EA"
REF02 Conditional Medical Record Number 0127 AN 1 30
REF03 Not Used
End Loop 2210

Begin Loop 2300 Max. Use: 100
130 CLM Mandatory Health Claim Max. Use: 1
CLM01 Mandatory Patient Control Number 1028 AN 1 38
CLM02 Mandatory Total Claim Charges 0782 R 1 15
CLM03 Mandatory Claim Editing Indicator 1032 "MA"
CLM04 Not Used
CLM05 Optional Type of Bill C023 Composite
-01 Mandatory Type of Bill Positions 1-2 1331 AN 1 2
-02 Optional Facility Code Qualifier 1332 "A"
-03 Optional Type of Bill Position 3 1325 ID 1 1
CLM06 Not Used
CLM07 Not Used
CLM08 Mandatory Assignment of Benefits Indicator 1073 ID 1 1

	CLM09	Optional	Release of Information Code	1363 ID 1 1
	CLM10	**Not Used**		
	CLM11	**Not Used**		
	CLM12	**Not Used**		
	CLM13	**Not Used**		
	CLM14	**Not Used**		
	CLM15	**Not Used**		
	CLM16	**Not Used**		
	CLM17	**Not Used**		
	CLM18	**Not Used**		
	CLM19	**Not Used**		
	CLM20	**Not Used**		
135.A	DTP	Conditional	Statement Covers Period	Max. Use: 2
	DTP01	Mandatory	Date/Time Qualifier	0374 "232" and “233"
	DTP02	Mandatory	Date Time Period Format Qualifier	1250 "D8"
	DTP03	Mandatory	Date Time Period	1251 AN 1 35
135.B	DTP	Conditional	Admission Date	Max. Use: 1
	DTP01	Mandatory	Date/Time Qualifier	0374 "435"
	DTP02	Mandatory	Date Time Period Format Qualifier	1250 “DT”
	DTP03	Mandatory	Admission Date/Admission Hour	1251 AN 1 35
135.C	DTP	Optional	Discharge Date/Hour	Max. Use: 2
	DTP01	Mandatory	Date/Time Qualifier	0374 "096"
	DTP02	Mandatory	Date Time Period Format Qualifier	1250 "TM"
	DTP03	Mandatory	Discharge Date/Hour	1251 AN 1 35
135.D	DTP	Conditional	Start of Care (SOC) Date	Max. Use: 1
	DTP01	Mandatory	Date/Time Qualifier	0374 "454"
	DTP02	Mandatory	Date Time Period Format Qualifier	1250 "D8"
	DTP03	Mandatory	Discharge Date/Hour	1251 AN 1 35
135.E	DTP	Optional	Date of Onset	Max. Use: 1
	DTP01	Mandatory	Date/Time Qualifier	0374 "431"
	DTP02	Mandatory	Date Time Period Format Qualifier	1250 "D8"
	DTP03	Mandatory	Date Time Period	1251 AN 1 35
135.F	DTP	Conditional	Date of Surgery	Max. Use: 1
	DTP01	Mandatory	Date/Time Qualifier	0374 "456"
	DTP02	Mandatory	Date Time Period Format Qualifier	1250 “D8”
	DTP03	Mandatory	Date Time Period	1251 AN 1 35
135.G	DTP	Optional	Last Seen Date	Max. Use: 1
	DTP01	Mandatory	Date/Time Qualifier	0374 "304"
	DTP02	Mandatory	Date Time Period Format Qualifier	1250 "D8"
	DTP03	Mandatory	Date Time Period	1251 AN 1 35
135.H	DTP	Optional	Verbal SOC Date	Max. Use: 1
	DTP01	Mandatory	Date/Time Qualifier	0374 "150"
	DTP02	Mandatory	Date Time Period Format Qualifier	1250 “D8”
	DTP03	Mandatory	Date Time Period	1251 AN 1 35
135.I	DTP	Optional	Date of Secondary Diagnosis - 1	Max. Use: 1
	DTP01	Mandatory	Date/Time Qualifier	0374 "438"
	DTP02	Mandatory	Date Time Period Format Qualifier	1250 "D8"
	DTP03	Mandatory	Date Time Period	1251 AN 1 35

135.J	DTP	Optional	Date of Secondary Diagnosis - 2	Max. Use: 1
	DTP01	Mandatory	Date/Time Qualifier	0374 "447"
	DTP02	Mandatory	Date Time Period Format Qualifier	1250 "D8"
	DTP03	Mandatory	Discharge Date/Hour	1251 AN 1 35
135.K	DTP	Optional	Date Physician Last Contacted Patient	Max. Use: 1
	DTP01	Mandatory	Date/Time Qualifier	0374 "911"
	DTP02	Mandatory	Date Time Period Format Qualifier	1250 "D8"
	DTP03	Mandatory	Discharge Date/Hour	1251 AN 1 35
140	CL1	Conditional	Claim Codes	Max. Use: 1
	CL101	Optional	Admission Type Code	1315 ID 1 1
	CL102	Optional	Admission Source Code	1314 ID 1 1
	CL103	Optional	Patient Status Code	1352 ID 1 2
	CL104	**Not Used**		
145	DN1	**Not Used**		
150	DN2	**Not Used**		
155	PWK	**Not Used**		
160	CN1	**Not Used**		
165	DSB	**Not Used**		
170	UR	**Not Used**		
175.A	AMT	Optional	Patient Amount Paid	Max. Use: 1
	AMT01	Mandatory	Amount Qualifier Code	0522 "F5"
	AMT02	Mandatory	Patient Amount Paid	0782 R 1 15
	AMT03	**Not Used**		
175.B	AMT	Optional	Patient Balance Due	Max. Use: 1
	AMT01	Conditional	Amount Qualifier Code	0522 "F3"
	AMT02	Conditional	Patient Balance Due	0782 R 1 15
	AMT03	**Not Used**		

180.A	REF	Optional	Original ICN/DCN Number	Max. Use: 1	
	REF01	Mandatory	Reference Number Qualifier	0128 "F8"	
	REF02	Conditional	Original ICN/DCN Number	0127 AN 1 30	
	REF03	**Not Used**			
180.AA	REF	Optional	Invest. Device Exemption Number	Max. Use: 1	
	REF01	Mandatory	Reference Number Qualifier	0128 "LX"	
	REF02	Conditional	IDE Number	0127 AN 1 30	
	REF03	**Not Used**			
180.B	REF	Optional	Data ID	Max. Use: 1	
	REF01	Mandatory	Reference Number Qualifier	0128 "DD"	
	REF02	Conditional	Data ID	0127 AN 1 30	
	REF03	**Not Used**			
185	K3	**Not Used**			
190.A	NTE	Optional	Billing Remarks	Max. Use: 20	
	NTE01	Optional	Note Reference Code	0363 "ADD"	
	NTE02	Mandatory	Billing Remarks	0352 AN 1 80	
190.B	NTE	Optional	Home Health Corresponding Data	Max. Use: 20	
	NTE01	Optional	Note Reference Code	0363 ID 3 3	
	NTE02	Mandatory	Corresponding Data	0352 AN 1 80	
195	CR1	**Not Used**			
200	CR2	**Not Used**			
205	CR3	**Not Used**			
210	CR4	**Not Used**			
215	CR5	**Not Used**			
216	CR6	Optional	Home Health Care Certification	Max. Use: 1	
	CR601	Mandatory	Prognosis Code	0923 ID 1 1	
	CR602	Conditional	Start of Care (SOC) Date	0373 DT 6 6	**(NOTE 135.D DTP)**
	CR603	Conditional	Date Time Period Format Qualifier	1250 "RD8"	
	CR604	Conditional	Certification Period	1251 AN 1 35	
	CR605	**Not Used**			
	CR606	Optional	Patient Receiving Care in 1861(j)(1)	1073 ID 1 1	
	CR607	Mandatory	Medicare Covered	1073 ID 1 1	
	CR608	Mandatory	Cert/Recert/Mod	1322 ID 1 1	
	CR609	Conditional	Date of Surgery	0373 DT 6 6	**(NOTE 135.F DTP)**
	CR610	Conditional	Product/Service ID Qualifier	0235 "ID"	
	CR611	Conditional	Surgical Procedure Code	1137 AN 1 15	
	CR612	**Not Used**			
	CR613	**Not Used**			
	CR614	**Not Used**			
	CR615	Conditional	Date Time Period Format Qualifier	1250 "RD8"	
	CR616	Conditional	Date Range - Last Inpatient Stay	1251 AN 1 35	
	CR617	Conditional	Type of Facility	1384 ID 1 1	
	CR618	**Not Used**			
	CR619	**Not Used**			
	CR620	**Not Used**			
	CR621	**Not Used**			
219	CR8	**Not Used**			

220.A	CRC	Optional	Home Health Functional Limitations	Max. Use: 3
	CRC01	Mandatory	Code Category	1136 "75"
	CRC02	Mandatory	Conditions Apply / Do Not Apply	1073 ID 1 1
	CRC03	Mandatory	Condition Indicator	1321 ID 2 2
	CRC04	Optional	Condition Indicator	1321 ID 2 2
	CRC05	Optional	Condition Indicator	1321 ID 2 2
	CRC06	Optional	Condition Indicator	1321 ID 2 2
	CRC07	Optional	Condition Indicator	1321 ID 2 2
220.B	CRC	Optional	Home Health Activities Permitted	Max. Use: 3
	CRC01	Mandatory	Code Category	1136 "76"
	CRC02	Mandatory	Conditions Apply / Do Not Apply	1073 ID 1 1
	CRC03	Mandatory	Condition Indicator	1321 ID 2 2
	CRC04	Optional	Condition Indicator	1321 ID 2 2
	CRC05	Optional	Condition Indicator	1321 ID 2 2
	CRC06	Optional	Condition Indicator	1321 ID 2 2
	CRC07	Optional	Condition Indicator	1321 ID 2 2
220.C	CRC	Optional	Home Health Mental Status	Max. Use: 3
	CRC01	Mandatory	Code Category	1136 "77"
	CRC02	Mandatory	Conditions Apply / Do Not Apply	1073 ID 1 1
	CRC03	Mandatory	Condition Indicator	1321 ID 2 2
	CRC04	Optional	Condition Indicator	1321 ID 2 2
	CRC05	Optional	Condition Indicator	1321 ID 2 2
	CRC06	Optional	Condition Indicator	1321 ID 2 2
	CRC07	Optional	Condition Indicator	1321 ID 2 2
225.A	HI	Optional	Health Care Information Codes	Max. Use: 25
	HI01	Mandatory	Health Care Code Information	C022 Composite
	-01	Mandatory	Health Care Codes	1270 "BJ"
	-02	Mandatory	Admitting Diagnosis Code	1271 AN 1 20
	-03	**Not Used**		
	-04	**Not Used**		
	-05	**Not Used**		
	-06	**Not Used**		
	HI02	Optional	Health Care Code Information	C022 Composite
	-01	Mandatory	Health Care Codes	1270 "BK"
	-02	Mandatory	Principle Diagnosis Code	1271 AN 1 20
	-03	**Not Used**		
	-04	**Not Used**		
	-05	**Not Used**		
	-06	**Not Used**		
	HI03	Optional	Health Care Code Information	C022 Composite
	-01	Mandatory	Health Care Codes	1270 "BF"
	-02	Mandatory	Other Diagnosis Code-1	1271 AN 1 20
	-03	**Not Used**		
	-04	**Not Used**		
	-05	**Not Used**		
	-06	**Not Used**		

HI04 Optional Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "BF"
-02 Mandatory Other Diagnosis Code-2 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Not Used
-06 Not Used

HI05 Optional Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "BF"
-02 Mandatory Other Diagnosis Code-3 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Not Used
-06 Not Used

HI06 Optional Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "BF"
-02 Mandatory Other Diagnosis Code-4 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Not Used
-06 Not Used

HI07 Optional Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "BF"
-02 Mandatory Other Diagnosis Code-5 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Not Used
-06 Not Used

HI08 Optional Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "BF"
-02 Mandatory Other Diagnosis Code-6 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Not Used
-06 Not Used

HI09 Optional Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "BF"
-02 Mandatory Other Diagnosis Code-7 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Not Used
-06 Not Used

HI10 Optional Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "BF"
-02 Mandatory Other Diagnosis Code-8 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Not Used
-06 Not Used

HI11	Optional	Health Care Code Information	C022	Composite	
-01	Mandatory	Health Care Codes		1270	"BN"
-02	Mandatory	E-Code		1271	AN 1 20
-03	Not Used				
-04	Not Used				
-05	Not Used				

	-06	**Not Used**					
	HI12	**Not Used**					
225.B	HI	Optional	Health Care Information Codes	Max. Use: 25			
	HI01	Mandatory	Health Care Code Information	C022 Composite			
	-01	Mandatory	Health Care Codes	1270 "BR"			
	-02	Mandatory	Principle Procedure Code	1271 AN	1	20	
	-03	Conditional	Date Time Period Format Qualifier	1250 "D8"			
	-04	Conditional	Procedure Date	1251 AN	1	35	
	-05	**Not Used**					
	-06	**Not Used**					
	HI02	Optional	Health Care Code Information	C022 Composite			
	-01	Mandatory	Health Care Codes	1270 "BQ"			
	-02	Mandatory	Other Procedure Code	1271 AN	1	20	
	-03	Conditional	Date Time Period Format Qualifier	1250 "D8"			
	-04	Conditional	Procedure Date	1251 AN	1	35	
	-05	**Not Used**					
	-06	**Not Used**					
	HI03	Optional	Health Care Code Information	C022 Composite			
	-01	Mandatory	Health Care Codes	1270 "BQ"			
	-02	Mandatory	Other Procedure Code - 2	1271 AN	1	20	
	-03	Conditional	Date Time Period Format Qualifier	1250 "D8"			
	-04	Conditional	Procedure Date	1251 AN	1	35	
	-05	**Not Used**					
	-06	**Not Used**					
	HI04	Optional	Health Care Code Information	C022 Composite			
	-01	Mandatory	Health Care Codes	1270 "BQ"			
	-02	Mandatory	Other Procedure Code - 3	1271 AN	1	20	
	-03	Conditional	Date Time Period Format Qualifier	1250 "D8"			
	-04	Conditional	Procedure Date	1251 AN	1	35	
	-05	**Not Used**					
	-06	**Not Used**					
	HI05	Optional	Health Care Code Information	C022 Composite			
	-01	Mandatory	Health Care Codes	1270 "BQ"			
	-02	Mandatory	Other Procedure Code - 4	1271 AN	1	20	
	-03	Conditional	Date Time Period Format Qualifier	1250 "D8"			
	-04	Conditional	Procedure Date	1251 AN	1	35	
	-05	**Not Used**					
	-06	**Not Used**					
	HI06	Optional	Health Care Code Information	C022 Composite			
	-01	Mandatory	Health Care Codes	1270 "BQ"			
	-02	Mandatory	Other Procedure Code - 5	1271 AN	1	20	
	-03	Conditional	Date Time Period Format Qualifier	1250 "D8"			
	-04	Conditional	Procedure Date	1251 AN	1	35	
	-05	**Not Used**					
	-06	**Not Used**					
			HI07 Through HI12 **Not Used**				
225.C	HI	Optional	Health Care Information Codes	Max. Use: 25			
	HI01	Mandatory	Health Care Code Information	C022 Composite			
	-01	Mandatory	Health Care Codes	1270 "BH"			

-02	Mandatory	Occurrence Code 1	1271 AN 1 20
-03	Conditional	Date Time Period Format Qualifier	1250 "D8"
-04	Conditional	Occurrence Date	1251 AN 1 35
-05	**Not Used**		
-06	**Not Used**		
HI02	Optional	Health Care Code Information	C022 Composite
-01	Mandatory	Health Care Codes	1270 "BH"
-02	Mandatory	Occurrence Code 2	1271 AN 1 20
-03	Conditional	Date Time Period Format Qualifier	1250 "D8"
-04	Conditional	Occurrence Date	1251 AN 1 35
-05	**Not Used**		
-06	**Not Used**		
HI03	Optional	Health Care Code Information	C022 Composite
-01	Mandatory	Health Care Codes	1270 "BH"
-02	Mandatory	Occurrence Code 3	1271 AN 1 20
-03	Conditional	Date Time Period Format Qualifier	1250 "D8"
-04	Conditional	Occurrence Date	1251 AN 1 35
-05	**Not Used**		
-06	**Not Used**		
HI04	Optional	Health Care Code Information	C022 Composite
-01	Mandatory	Health Care Codes	1270 "BH"
-02	Mandatory	Occurrence Code 4	1271 AN 1 20
-03	Conditional	Date Time Period Format Qualifier	1250 "D8"
-04	Conditional	Occurrence Date	1251 AN 1 35
-05	**Not Used**		
-06	**Not Used**		
HI05	Optional	Health Care Code Information	C022 Composite
-01	Mandatory	Health Care Codes	1270 "BH"
-02	Mandatory	Occurrence Code 5	1271 AN 1 20
-03	Conditional	Date Time Period Format Qualifier	1250 "D8"
-04	Conditional	Occurrence Date	1251 AN 1 35
-05	**Not Used**		
-06	**Not Used**		
HI06	Optional	Health Care Code Information	C022 Composite
-01	Mandatory	Health Care Codes	1270 "BH"
-02	Mandatory	Occurrence Code 6	1271 AN 1 20
-03	Conditional	Date Time Period Format Qualifier	1250 "D8"
-04	Conditional	Occurrence Date	1251 AN 1 35
-05	**Not Used**		
-06	**Not Used**		
HI07	Optional	Health Care Code Information	C022 Composite
-01	Mandatory	Health Care Codes	1270 "BH"
-02	Mandatory	Occurrence Code 7	1271 AN 1 20
-03	Conditional	Date Time Period Format Qualifier	1250 "D8"
-04	Conditional	Occurrence Date	1251 AN 1 35
-05	**Not Used**		
-06	**Not Used**		
HI08	Optional	Health Care Code Information	C022 Composite
-01	Mandatory	Health Care Codes	1270 "BH"
-02	Mandatory	Occurrence Code 8	1271 AN 1 20

-03	Conditional	Date Time Period Format Qualifier	1250 "D8"
-04	Conditional	Occurrence Date	1251 AN 1 35
-05	**Not Used**		
-06	**Not Used**		
HI09	Optional	Health Care Code Information	C022 Composite
-01	Mandatory	Health Care Codes	1270 "BH"
-02	Mandatory	Occurrence Code 9	1271 AN 1 20
-03	Conditional	Date Time Period Format Qualifier	1250 "D8"
-04	Conditional	Occurrence Date	1251 AN 1 35
-05	**Not Used**		
-06	**Not Used**		
HI10	Optional	Health Care Code Information	C022 Composite
-01	Mandatory	Health Care Codes	1270 "BH"
-02	Mandatory	Occurrence Code 10	1271 AN 1 20
-03	Conditional	Date Time Period Format Qualifier	1250 "D8"
-04	Conditional	Occurrence Date	1251 AN 1 35
-05	**Not Used**		
-06	**Not Used**		
HI11	**Not Used**		
HI12	**Not Used**		
225.D HI	Optional	Health Care Information Codes	Max. Use: 25
HI01	Mandatory	Health Care Code Information	C022 Composite
-01	Mandatory	Health Care Codes	1270 "BI"
-02	Mandatory	Occurrence Span Code 1	1271 AN 1 20
-03	Conditional	Date Time Period Format Qualifier	1250 "RD8"
-04	Conditional	Occurrence Span Date	1251 AN 1 35
-05	**Not Used**		
-06	**Not Used**		
HI02	Optional	Health Care Code Information	C022 Composite
-01	Mandatory	Health Care Codes	1270 "BI"
-02	Mandatory	Occurrence Span Code 2	1271 AN 1 20
-03	Conditional	Date Time Period Format Qualifier	1250 "RD8"
-04	Conditional	Occurrence Span Date	1251 AN 1 35
-05	**Not Used**		
-06	**Not Used**		
HI03	Optional	Health Care Code Information	C022 Composite
-01	Mandatory	Health Care Codes	1270 "BI"
-02	Mandatory	Occurrence Span Code 3	1271 AN 1 20
-03	Conditional	Date Time Period Format Qualifier	1250 "RD8"
-04	Conditional	Occurrence Span Date	1251 AN 1 35
-05	**Not Used**		
-06	**Not Used**		
HI04	Optional	Health Care Code Information	C022 Composite
-01	Mandatory	Health Care Codes	1270 "BI"
-02	Mandatory	Occurrence Span Code 4	1271 AN 1 20
-03	Conditional	Date Time Period Format Qualifier	1250 "RD8"
-04	Conditional	Occurrence Span Date	1251 AN 1 35
-05	**Not Used**		
-06	**Not Used**		

HI05 through HI12 **Not Used**

225.E HI	Optional	Health Care Information Codes	Max. Use: 25
HI01	Mandatory	Health Care Code Information	C022 Composite
-01	Mandatory	Health Care Codes	1270 "BG"

-02 Mandatory Condition Code 1 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Not Used
-06 Not Used
HI02 Optional Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "BG"
-02 Mandatory Condition Code 2 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Not Used
-06 Not Used
HI03 Optional Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "BG"
-02 Mandatory Condition Code 3 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Not Used
-06 Not Used
HI04 Optional Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "BG"
-02 Mandatory Condition Code 4 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Not Used
-06 Not Used
HI05 Optional Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "BG"
-02 Mandatory Condition Code 5 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Not Used
-06 Not Used
HI06 Optional Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "BG"
-02 Mandatory Condition Code 6 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Not Used
-06 Not Used
HI07 Optional Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "BG"
-02 Mandatory Condition Code 7 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Not Used
-06 Not Used
HI08 Optional Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "BG"
-02 Mandatory Condition Code 8 1271 AN 1 20

-03 Not Used
-04 Not Used
-05 Not Used
-06 Not Used
HI09 Optional Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "BG"
-02 Mandatory Condition Code 9 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Not Used
-06 Not Used
HI10 Optional Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "BG"
-02 Mandatory Condition Code 10 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Not Used
-06 Not Used
HI11 Not Used
HI12 Not Used

225.F HI Optional Health Care Information Codes Max. Use: 25
HI01 Mandatory Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "BE"
-02 Mandatory Value Code 1 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Optional Value Amount 0782 R 1 15
-06 Not Used
HI02 Optional Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "BE"
-02 Mandatory Value Code 2 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Optional Value Amount 0782 R 1 15
-06 Not Used
HI03 Optional Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "BE"
-02 Mandatory Value Code 3 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Optional Value Amount 0782 R 1 15
-06 Not Used

HI04 Optional Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "BE"
-02 Mandatory Value Code 4 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Optional Value Amount 0782 R 1 15
-06 Not Used
HI05 Optional Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "BE"
-02 Mandatory Value Code 5 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Optional Value Amount 0782 R 1 15
-06 Not Used
HI06 Optional Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "BE"
-02 Mandatory Value Code 6 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Optional Value Amount 0782 R 1 15
-06 Not Used
HI07 Optional Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "BE"
-02 Mandatory Value Code 7 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Optional Value Amount 0782 R 1 15
-06 Not Used
HI08 Optional Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "BE"
-02 Mandatory Value Code 8 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Optional Value Amount 0782 R 1 15
-06 Not Used
HI09 Optional Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "BE"
-02 Mandatory Value Code 9 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Optional Value Amount 0782 R 1 15
-06 Not Used
HI10 Optional Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "BE"
-02 Mandatory Value Code 10 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Optional Value Amount 0782 R 1 15
-06 Not Used

HI11 Optional Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "BE"
-02 Mandatory Value Code 11 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Optional Value Amount 0782 R 1 15
-06 Not Used
HI12 Optional Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "BE"
-02 Mandatory Value Code 12 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Optional Value Amount 0782 R 1 15
-06 Not Used

225.G HI Optional Health Care Information Codes Max. Use: 25
HI01 Mandatory Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "TC"
-02 Mandatory Treatment Code - 1 or 13 or 25 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Not Used
-06 Not Used
HI02 Optional Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "TC"
-02 Mandatory Treatment Code - 2 or 14 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Not Used
-06 Not Used
HI03 Optional Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "TC"
-02 Mandatory Treatment Code - 3 or 15 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Not Used
-06 Not Used
HI04 Optional Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "TC"
-02 Mandatory Treatment Code - 4 or 16 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Not Used
-06 Not Used
HI05 Optional Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "TC"
-02 Mandatory Treatment Code - 5 or 17 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Not Used

-06 Not Used
HI06 Optional Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "TC"
-02 Mandatory Treatment Code - 6 or 18 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Not Used
-06 Not Used
HI07 Optional Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "TC"
-02 Mandatory Treatment Code - 7 or 19 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Not Used
-06 Not Used
HI08 Optional Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "TC"
-02 Mandatory Treatment Code - 8 or 20 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Not Used
-06 Not Used
HI09 Optional Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "TC"
-02 Mandatory Treatment Code - 9 or 21 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Not Used
-06 Not Used
HI10 Optional Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "TC"
-02 Mandatory Treatment Code - 10 or 22 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Not Used
-06 Not Used
HI11 Optional Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "TC"
-02 Mandatory Treatment Code - 11 or 23 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Not Used
-06 Not Used
HI12 Optional Health Care Code Information C022 Composite
-01 Mandatory Health Care Codes 1270 "TC"
-02 Mandatory Treatment Code - 12 1271 AN 1 20
-03 Not Used
-04 Not Used
-05 Not Used

-06 Not Used

240.A QTY Conditional Covered Days Actual Max. Use: 1
QTY01 Mandatory Quantity Qualifier 0673 "CA"
QTY02 Mandatory Covered Days Actual 0380 R 1 15
QTY03 Optional Days 0355 "DA"

240.B QTY Optional Non-Covered Days Actual Max. Use: 1
QTY01 Mandatory Quantity Qualifier 0673 "NA"
QTY02 Mandatory Non-Covered Days Actual 0380 R 1 15
QTY03 Optional Days 0355 "DA"

240.C QTY Optional Co-Insurance Days Actual Max. Use: 1
QTY01 Mandatory Quantity Qualifier 0673 "CD"
QTY02 Mandatory Co-Insurance Days Actual 0380 R 1 15
QTY03 Optional Days 0355 "DA"

240.D QTY Optional Lifetime Reserve Days Actual Max. Use: 1
QTY01 Mandatory Quantity Qualifier 0673 "LA"
QTY02 Mandatory Lifetime Reserve Days Actual 0380 R 1 15
QTY03 Optional Days 0355 "DA"

241 HCP Not Used

Begin Loop 2305 Max. Use: 6

243 CR7 Optional Home Health Treatment Plan Certifica Max. Use: 1
CR701 Mandatory Discipline 0921 ID 2 2
CR702 Mandatory Visits (this bill) Related to Prior 1470 N0 1 9
CR703 Mandatory Total Visits Projected During this C 1470 N0 1 9

244 HSD Optional Health Care Services Delivery Max. Use: 12
HSD01 Conditional Quantity Qualifier 0673 "VS"
HSD02 Conditional Frequency Number - 1 0380 R 1 15
HSD03 Optional Frequency Period - 1 0355 ID 2 2
HSD04 Not Used
HSD05 Conditional Time Period Qualifier 0615 "35"
HSD06 Optional Duration - 1 0616 N0 1 3
HSD07 Not Used

HSD08 Not Used

End Loop 2305

245 LS Optional Loop Header Max. Use: 1
LS01 Mandatory Loop Identifier Code 0447 AN 1 4

Begin Loop 2310.A Max. Use: 9

250.A NM1 Mandatory Attending Physician Name Max. Use: 1
NM101 Mandatory Entity Identifier Code 0098 "71"
NM102 Mandatory Entity Type Qualifier 1065 "1"
NM103 Optional Attending Physician Last Name 1035 AN 1 35
NM104 Optional Attending Physician First Name 1036 AN 1 25
NM105 Optional Attending Physician Middle Name 1037 AN 1 25
NM106 Not Used
NM107 Not Used
NM108 Conditional Identification Code Qualifier 0066 "UP"
NM109 Conditional Attending Physician UPIN 0067 AN 2 20

255.A PRV Not Used

260.A N2 Not Used
265.A N3 Not Used
270.A N4 Optional Patient City, State, ZIP Max. Use: 1
N401 Not Used
N402 Not Used
N403 Optional Physician ZIP Code 0116 ID 3 11
N404 Not Used
N405 Not Used
N406 Not Used
271.A REF Not Used
275.A PER Not Used
End Loop 2310.A

Begin Loop 2310.B Max. Use: 9

250.B NM1 Optional Operating Physician Name Max. Use: 1
NM101 Mandatory Entity Identifier Code 0098 "72"
NM102 Mandatory Entity Type Qualifier 1065 "1"
NM103 Optional Operating Physician Last Name 1035 AN 1 35
NM104 Optional Operating Physician First Name 1036 AN 1 25
NM105 Optional Operating Physician Middle Name 1037 AN 1 25
NM106 Not Used
NM107 Not Used
NM108 Conditional Identification Code Qualifier 0066 "UP"
NM109 Conditional Operating Physician UPIN 0067 AN 2 20
255.B PRV Not Used
260.B N2 Not Used

265.B N3 Not Used
270.B N4 Not Used
271.B REF Not Used
275.B PER Not Used

End Loop 2310.B

Begin Loop 2310.C Max. Use: 9

250.C NM1 Optional Other Physician Name Max. Use: 1
NM101 Mandatory Entity Identifier Code 0098 "73"
NM102 Mandatory Entity Type Qualifier 1065 "1"
NM103 Optional Other Physician Last Name 1035 AN 1 35
NM104 Optional Other Physician First Name 1036 AN 1 25
NM105 Optional Other Physician Middle Name 1037 AN 1 25
NM106 Not Used
NM107 Not Used
NM108 Conditional Identification Code Qualifier 0066 "UP"
NM109 Conditional Other Physician UPIN 0067 AN 2 20

255.C PRV Not Used
260.C N2 Not Used
265.C N3 Not Used
270.C N4 Not Used

271.C REF Not Used

275.C PER Not Used

End Loop 2310.C

280 LE Optional Loop Trailer Max. Use: 1
LE01 Mandatory Loop Identifier Code 0447 AN 1 4

281 LS Optional Loop Header Max. Use: 1
LS01 Mandatory Loop Identifier Code 0447 AN 1 4

Begin Loop 2320 Max. Use: 10

285 SBR Conditional Additional Payor Information Max. Use: 1
SBR01 Mandatory Supplementary Payor Responsibility S 1138 ID 1 1
SBR02 Mandatory Patient Relationship to Insured 1069 ID 2 2
SBR03 Conditional Supplementary Payor Group or Number 0127 AN 1 30
SBR04 Optional Supplementary Payor Group Name 0093 AN 1 35
SBR05 Not Used
SBR06 Not Used
SBR07 Not Used
SBR08 Optional Employment Status Code 0584 ID 2 2
SBR09 Not Used
290 CAS Not Used
300.A AMT Optional Payor Amount Paid Max. Use: 15
AMT01 Mandatory Amount Qualifier Code 0522 "D"
AMT02 Mandatory Monetary Amount 0782 R 1 15
AMT03 Not Used
300.B AMT Optional Estimated Amount Due Max. Use: 15
AMT01 Mandatory Amount Qualifier Code 0522 "C5"
AMT02 Mandatory Monetary Amount 0782 R 1 15
AMT03 Not Used
305 DMG Conditional Other Insured Date of Birth and Sex Max. Use: 1
DMG01 Conditional Date Time Period Format Qualifier 1250 "D8"
DMG02 Conditional Other Insured Date of Birth 1251 AN 1 35
DMG03 Mandatory Other Insured Sex 1068 ID 1 1
DMG04 Not Used
DMG05 Not Used
DMG06 Not Used
DMG07 Not Used
DMG08 Not Used
310 OI Conditional Supplementary Payor Type of Insuranc Max. Use: 1
OI01 Mandatory Supplementary Payor Type of Insuranc 1032 ID 1 2
OI02 Not Used
OI03 Optional Assignment of Benefits Indicator 1073 ID 1 1
OI04 Not Used
OI05 Not Used

OI06 Optional Release of information Indicator 1363 ID 1 1
315 MIA Not Used
320 MOA Not Used
Begin Loop 2330 Max. Use: 10
325.A NM1 Conditional Supplementary Payor Name Max. Use: 1
NM101 Mandatory Entity Identifier Code 0098 "PR"
NM102 Mandatory Entity Type Qualifier 1065 "2"
NM103 Conditional Supplementary Payor Name 1035 AN 1 35
NM104 Not Used
NM105 Not Used
NM106 Not Used
NM107 Not Used
NM108 Conditional Identification Code Qualifier 0066 "PI"
NM109 Conditional Supplementary Payor Identification N 0067 AN 2 20
330.A N2 Not Used
335.A N3 Not Used
340.A N4 Not Used
345 PER Not Used
350 DTP Not Used
355.AA REF Optional Treatment Authorization Number Max. Use: 3
REF01 Mandatory Reference Number Qualifier 0128 "BB"
REF02 Mandatory Treatment Authorization Number 0127 AN 1 30
REF03 Not Used
355.AB REF Optional Provider Identification Number Max. Use: 3
REF01 Mandatory Reference Number Qualifier 0128 "G2"
REF02 Mandatory Provider Identification Number 0127 AN 1 30
REF03 Not Used
355.AC REF Optional Original ICN/DCN Number Max. Use: 3
REF01 Mandatory Reference Number Qualifier 0128 "F8"
REF02 Mandatory Original ICN/DCN Number 0127 AN 1 30
REF03 Not Used
325.B NM1 Conditional Other Insured Name Max. Use: 1
NM101 Mandatory Entity Identifier Code 0098 "IL"
NM102 Mandatory Entity Type Qualifier 1065 "1"
NM103 Mandatory Other Insured Last Name 1035 AN 1 35
NM104 Mandatory Other Insured First Name 1036 AN 1 25
NM105 Optional Other Insured Middle Initial 1037 AN 1 25
NM106 Not Used
NM107 Not Used
NM108 Conditional Identification Code Qualifier 0066 "C1"
NM109 Conditional Other Insured Identificatiion Number 0067 AN 2 20
330.B N2 Not Used

335.B N3 Optional Other Insured Address Max. Use: 2
N301 Mandatory Other Insured Address Line 1 0166 AN 1 35
N302 Optional Other Insured Address Line 2 0166 AN 1 35
340.B N4 Optional Other Insured City, State, ZIP Max. Use: 1
N401 Optional Other Insured City 0019 AN 2 30
N402 Optional Other Insured State 0156 ID 2 2
N403 Optional Other Insured ZIP 0116 ID 3 11
N404 Not Used
N405 Not Used
N406 Not Used
325.C NM1 Conditional Subscriber's Employer Name Max. Use: 1
NM101 Mandatory Entity Identifier Code 0098 "84"
NM102 Mandatory Entity Type Qualifier 1065 "2"
NM103 Mandatory Subscriber's Employer Name 1035 AN 1 35
NM104 Not Used
NM105 Not Used
NM106 Not Used
NM107 Not Used
NM108 Not Used
NM109 Not Used
330.C N2 Not Used

335.C N3 Optional Subscriber's Employer Address Max. Use: 2
N301 Mandatory Employer Address Line 1 0166 AN 1 35
N302 Not Used

340.C N4 Optional Subscriber's Employer City, State, Z Max. Use: 1
N401 Optional Subscriber's Employer City 0019 AN 2 30
N402 Optional Subscriber's Employer State 0156 ID 2 2
N403 Optional Subscriber's Employer ZIP 0116 ID 3 11
N404 Not Used
N405 Not Used
N406 Not Used

325.D NM1 Conditional Other Employer Name Max. Use: 1
NM101 Mandatory Entity Identifier Code 0098 "ES"
NM102 Mandatory Entity Type Qualifier 1065 "2"
NM103 Conditional Other Employer Name 1035 AN 1 35
NM104 Not Used
NM105 Not Used
NM106 Not Used
NM107 Not Used
NM108 Not Used
NM109 Not Used
330.D N2 Not Used
335.D N3 Optional Other Employer Address Max. Use: 2
N301 Mandatory Employer Address Line 1 0166 AN 1 35
N302 Not Used
340.D N4 Optional Other Employer City, State, ZIP Max. Use: 1

N401 Optional Other Employer City 0019 AN 2 30
N402 Optional Other Employer State 0156 ID 2 2
N403 Optional Other Employer ZIP 0116 ID 3 11
N404 Not Used
N405 Not Used
N406 Not Used
355.D REF Optional Employment Status Code Max. Use: 3
REF01 Mandatory Reference Number Qualifier 0128 "ZZ"
REF02 Mandatory Other Employment Status Code 0127 AN 1 30
REF03 Conditional Description 0352 AN 1 80
325.E NM1 Conditional Supp Payor Name (Contract #) Max. Use: 1
NM101 Mandatory Entity Identifier Code 0098 "PR"
NM102 Mandatory Entity Type Qualifier 1065 "2"
NM103 Conditional Supplementary Payor Name 1035 AN 1 35
NM104 - NM107 Not Used
NM108 Conditional Identification Code Qualifier 0066 "ZY"
NM109 Conditional Suppl Payor Id (Contract #) 0067 AN 2 20
End Loop 2330
End Loop 2320
365 LE Optional Loop Trailer Max. Use: 1
LE01 Mandatory Loop Identifier Code 0447 AN 1 4
Begin Loop 2400 Max. Use: 10000
385 LX Mandatory Assigned Number Max. Use: 1
LX01 Mandatory Assigned Number 0554 N0 1 6
390 SV1 Not Used
395 SV2 Mandatory Institutional Service Max. Use: 1
SV201 Conditional Revenue Center Code 0234 AN 1 40
SV202 Conditional Composite Medical Procedure Identifi C003 Composite
-01 Mandatory Product/Service ID Qualifier 0235 ID 2 2
-02 Mandatory HCPCS Procedure Code 0234 AN 1 40
-03 Optional Modifier 1 1339 AN 2 2
-04 Optional Modifier 2 1339 AN 2 2
-05 Not Used
-06 Not Used
-07 Not Used
SV203 Optional Total Charges 0782 R 1 15
SV204 Conditional Unit or Basis for Meas. Code 0355 ID 2 2
SV205 Conditional Quantity 0380 R 1 15
SV206 Optional Accommodations Rate 1371 R 1 10
SV207 Optional Non-Covered Charges 0782 R 1 15
SV208 - SV210 Not Used
400 SV3 Not Used
401 TOO Not Used
405 SV4 Not Used
420 SV5 Not Used
425 SV6 Not Used
430 SV7 Not Used

435	HI	**Not Used**		
440	PWK	**Not Used**		
445	CR1	**Not Used**		
450	CR2	**Not Used**		
455	CR3	**Not Used**		
460	CR4	**Not Used**		
465	CR5	**Not Used**		
470	CRC	**Not Used**		
475	DTP	Conditional	Outpatient Service Date/HIPPS	Max. Use: 1
	DTP01	Mandatory	Date/Time Qualifier	0374 "472"
	DTP02	Mandatory	Date Time Period Format Qualifier	1250 "D8"
	DTP03	Mandatory	Date of Service	1251 AN 1 35
480	QTY	**Not Used**		
481	MEA	**Not Used**		
485	CN1	**Not Used**		
490	REF	**Not Used**		
495	AMT	**Not Used**		
500	K3	**Not Used**		
505	NTE	**Not Used**		
510	PS1	**Not Used**		
511	HCP	**Not Used**		
			Begin Loop 2410 Max. Use: 10	
512	LIN	**Not Used**		
514	CTP	**Not Used**		
			End Loop 2410	
515	LS	**Not Used**		
			Begin Loop 2420 Max. Use: 1	
520	NM1	**Not Used**		
525	PRV	**Not Used**		

530 N2 Not Used
535 N3 Not Used
540 N4 Not Used
541 REF Not Used
545 PER Not Used

End Loop 2420

550 LE Not Used

Begin Loop 2430 Max. Use: 1

556 SVD Not Used

557 CAS Not Used

558 DTP Not Used

End Loop 2430

End Loop 2400

End Loop 2300

End Loop 2200

End Loop 2100

End Loop 2000

560 SE Mandatory Transaction Set Trailer Max. Use: 1
SE01 Mandatory Number of Included Segments 0096 N0 1 10
SE02 Mandatory Transaction Set Control Number 0329 AN 4 9

TABLE 4

Positn.	Seg+E	Requirement	Segment & Element Name	Ele#	Attributes
010	GE	Mandatory	Functional Group Trailer	Max. Use: 1	
	GE01	Mandatory	Number of Transaction Sets Included	0097	N0 1 6
	GE02	Mandatory	Group Control Number	0028	N0 1 9
020	IEA	Mandatory	Interchange Control Trailer	Max. Use: 1	
	IEA01	Mandatory	Number of Included Functional Groups	I16	N0 1 5
	IEA02	Mandatory	Interchange Control Number	I12	N0 9 9

END OF TABLES

X12 Segment Name: ISA Interchange Control Header
Loop: ----
Max. Use: 1
X12 Purpose: To start and identify an interchange of zero or more functional groups and interchange-related control segments
Usage: Mandatory
Example: ISA*00*.....*01*SECRET....*ZZ*MEDEX.....*ZZ*0305.....*9306
02*1253*U*00305*000000905*1*T*:~
Comments: The ISA is a fixed record length segment and all positions within each of the data elements must be filled. The first element separator defines the element separator to be used through the entire exchange. The segment terminator used after the ISA defines the segment terminator to be used throughout the entire exchange. The white spaces in the example have been replaced by periods for clarity.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
ISA01 I01 ID 2 2 M	Authorization Information Qualifier Code to identify the type of information in the Authorization Information. Codes: 00 No Authorization Information Present (No Meaningful Information in I02) 03 Additional Data Identification	
ISA02 I02 AN 10 10 M	Authorization Information Information used for additional identification or authorization of the interchange sender or the data in the interchange; the type of information is set by the Authorization Information Qualifier (I01)	
ISA03 I03 ID 2 2 M	Security Information Qualifier Code to identify the type of information in the Security Information. Codes: 00 No Security Information Present (No Meaningful Information in I04) 01 Password	
ISA04 I04 AN 10 10 M	Security Information This is used for identifying the security information about the interchange sender or the data in the	

interchange; the type of information is set by the Security Information Qualifier (I03)

ISA05 I05
ID 2 2 M
Interchange ID Qualifier
Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified.
Codes:
ZZ Mutually Defined

ISA06 I06
AN 15 15 M
Interchange Sender ID
Transmission Submitter Identification Number. Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element. The identification code assigned by the intermediary to the submitter of this transmission. Space fill the submitter number to the right for a total length of 15 characters. SUBMITTER ID.

ISA07 I05
ID 2 2 M
Interchange ID Qualifier
Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified.
Codes:
ZZ Mutually Defined

ISA08 I07
AN 15 15 M
Interchange Receiver ID
Intermediary Identification Number. Identification code published by the receiver of the data. When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them. The identification code for the receiver of this transmission. INTERMEDIARY NUMBER.

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ISA09 I08
DT 6 6 M
Interchange Date
File Creation Date
Date of the interchange.
Format YYMMDD.

ISA10 I09 Interchange Time
TM 4 4 M File Creation Time
Time of the interchange.
Format HHMM. Use a minimum of four zeroes if there is no significant data for this field.

ISA11 I10 Interchange Control Standards Identifier
ID 1 1 M Code to identify the agency responsible for the control standard used by the message that is enclosed by the interchange header and trailer.
Codes:
U U.S. EDI Community of ASC X12, TDCC, and UCS

ISA12 I11 Interchange Control Version Number
ID 5 5 M ANSI Version Code
This version number covers the interchange control segments.
The version code may vary, if or when HCFA chooses to adopt the next ASC X12 Version. The correct value for this version is "00305".
Codes:

ISA13 I12 Interchange Control Number
N0 9 9 M A control number assigned by the interchange sender
The Interchange Control Number, ISA13, must be identical to the one found in the associated Interchange Trailer IEA02. Cannot be left blank.

ISA14 I13 Acknowledgment Requested
ID 1 1 M Code sent by the sender to request an interchange acknowledgment (TA1)
Codes:
0 No Acknowledgment Requested
1 Interchange Acknowledgment Requested

ISA15 I14 Test Indicator
ID 1 1 M Code to indicate whether data enclosed by this interchange envelope is test or production.
Codes: UB92 5.0 01-18
P Production Data
T Test Data

ISA16	I15	Component Element Separator
AN	1 1 M	This field provides the delimiter used to separate component data elements within a composite data structure; this value must be different than the data element separator and the segment terminator Cannot be left blank.

X12 Segment Name: GS Functional Group Header
Loop: ----
Max. Use: 1
X12 Purpose: To indicate the beginning of a functional group and to provide control information
Usage: Mandatory
Example: GS*HC*MEDEX*0305*930602*1253*1*X*003051~
Comments: All fields must contain data.

Semantic Note: GS04 is the Group Date.
Semantic Note: GS05 is the Group Time.
Semantic Note: The data interchange control number GS06 in this header must be identical to the same data element in the associated Functional Group Trailer GE02.

X12 Comment: A functional group of related transaction sets, within the scope of X12 standards, consists of a collection of similar transaction sets enclosed by a functional group header and a functional group trailer.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
GS01 0479 ID 2 2 M	Functional Identifier Code Code identifying a group of application related Transaction Sets. Codes: HC Health Care Claim (837)	
GS02 0142 AN 2 15 M	Application Sender's Code Transmission Submitter Identification Number Code identifying party sending transmission. Codes agreed to by trading partners. The identification code assigned by the intermediary to the submitter of this transmission.	01-02
GS03 0124 AN 2 15 M	Application Receiver's Code Intermediary Identification Number Code identifying party receiving transmission. Codes agreed to by trading partners. The identification code for the receiver of this transmission. This number must contain at least 3 digits. INTERMEDIARY NUMBER.	01-06, 01-07
GS04 0373 DT 6 6 M	Date Group Creation Date Date (YYMMDD).	01-19

DATE OF RECEIPT.

GS05 0337 Time
TM 4 8 M Group Creation Time
Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99)
Format HHMM. Use a minimum of four zeroes if there is no significant data for this field. FILE CREATION TIME.

GS06 0028 Group Control Number
N0 1 9 M Assigned number originated and maintained by the sender. The group control number, GS06, must be identical to the one found in the associated function trailer GE02. Start with 1 and increment by 1 for each functional group within this interchange.

GS07 0455 Responsible Agency Code
ID 1 2 M Code used in conjunction with Data Element 480 to identify the issuer of the standard.
Codes:
X Accredited Standards Committee X12

GS08 0480 Version / Release / Industry Identifier
AN 1 12 M Code
ANSI Version Code
Code indicating the version, release, subrelease, and industry identifier of the EDI standard being used, including the GS and GE segments. If code in DE455 in GS segment is X, then in DE 480 positions 1-3 are the version number; positions 4-6 are the release and subrelease, level of the version; and positions 7-12 are the industry or trade association identifiers (optionally assigned by user). If code in DE455 in GS segment is T, then other formats are allowed. The version code may vary, if or when HCFA chooses to adopt the next ASC X12 Version

Codes:
003051

Draft Standards Approved for Publication by HCFA 04/01/98

X12 Segment Name: ST Transaction Set Header
Loop: ----
Max. Use: 1
X12 Purpose: To indicate the start of a transaction set and to assign a control number
Usage: Mandatory
Example: ST*837*112233~

Semantic Note: The transaction set identifier (ST01) used by the translation routines of the interchange partners to select the appropriate transaction set definition (e.g., 810 selects the invoice transaction set).

Element Attributes	Data Element Usage
ST01 0143 ID 3 3 M	Transaction Set Identifier Code Code uniquely identifying a Transaction Set. Codes: 837 X12.86 Health Care Claim
ST02 0329 AN 4 9 M	Transaction Set Control Number Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set

X12 Segment Name: BGN Beginning Segment
Loop: ----
Max. Use: 1
X12 Purpose: To indicate the beginning of a transaction set.
Usage: Mandatory
Example: BGN*00*C10027*930704~
Comments: A new transaction set must be utilized for each type of purpose code in BGN01.

Syntax Note: C0504 - If BGN05 is present, then BGN04 must be present.

Semantic Note: BGN02 is the transaction set reference number.
Semantic Note: BGN03 is the transaction set date.
Semantic Note: BGN04 is the transaction set time.
Semantic Note: BGN05 is the transaction set time qualifier.
Semantic Note: BGN06 is the transaction set reference number of a previously sent transaction affected by the current transaction.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
BGN01 0353 ID 2 2 M	Transaction Set Purpose Code Code identifying purpose of transaction set. Codes: 00 Original	
BGN02 0127 AN 1 30 M	Reference Number Submission Number Reference number or identification number as defined for a particular Transaction Set, or as specified by the Reference Number Qualifier. The inventory file number of the tape reel or transmission assigned by the submitter's system. FILE SEQUENCE/SERIAL NUMBER.	01-17
BGN03 0373 DT 6 6 M	Date Creation Date Date (YYMMDD). Identifies the date the submitter created the file. PROCESSING DATE.	01-20
BGN04 0337	Time Not Used.	
BGN05 0623	Time Code Not Used.	

BGN06 0127	Reference Number Not Used.
BGN07 0640	Transaction Type Code Not Used.
BGN08 0306	Action Code Not Used.

X12 Segment Name: REF Reference Numbers
Name: Version Number
Loop: ----
Max. Use: 1
X12 Purpose: To specify identifying numbers.
Purpose: This segment conveys the version number for the provider application system used to process the claims.
Usage: Required
Example: REF*F1*3A.01~

Syntax Note: R0203 - At least one of REF02 or REF03 must be present.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
REF01 0128 ID 2 2 M	Reference Number Qualifier Code qualifying the Reference Number. Codes: F1 Version Code - National Identifies the release of a set of information or requirements to distinguish from the previous or future sets that may differ; the release in question is on the national level	
REF02 0127 AN 1 30 M	Reference Number Medicare A Implementation Guide Version Number Reference number or identification number as defined for a particular Transaction Set, or as specified by the Reference Number Qualifier. Use "3A.01" for this version.	
REF03 0352	Description Not Used.	

X12 Segment Name: NM1 Individual or Organizational Name
Name: Submitter Name and ID
Loop: 1000
Max. Use: 1
X12 Purpose: To supply the full name of an individual or organizational entity
Purpose: To identify the submitter or billing service or clearinghouse.
Usage: Mandatory
Example: NM1*41*2*HOSPITAL BILLING SERVICE*****24*731234567~

Syntax Note: P0809 - If either NM108 or NM109 is present, then the other must be present.

Semantic Note: NM102 qualifies NM103.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
NM101 0098 ID 2 2 M	Entity Identifier Code Code identifying an organizational entity, a physical location, or an individual Codes: 41 Submitter Entity transmitting transaction set	
NM102 1065 ID 1 1 M	Entity Type Qualifier Code qualifying the type of entity. Codes: 2 Non-Person Entity	
NM103 1035 AN 1 35 O	Name Last or Organization Name Submitter Name Individual last name or organizational name The name of the submitter to which the receiver should direct inquiries regarding this file.	01-09
NM104 1036	Name First Not Used.	
NM105 1037	Name Middle Not Used.	
NM106 1038	Name Prefix Not Used.	

NM107 1039	Name Suffix Not Used.	
NM108 0066 ID 1 2 M	Identification Code Qualifier Submitter/Biller Identification Number Code designating the system/method of code structure used for Identification Code (67). Codes: 24 Employer's Identification Number	
NM109 0067 AN 2 20 M	Identification Code Submitter Identifier Code identifying a party or other code. Identifies the submitter as defined by the receiver. SUBMITTER EIN.	01-02, 95-02, 99-02

X12 Segment Name: N2 Additional Name Information
Name: Additional Submitter Name
Loop: 1000
Max. Use: 1
X12 Purpose: To specify additional names or those longer than 35 characters in length
Usage: Optional
Comments: This segment should be utilized only if NM103 is insufficient in size.

Element Attributes	Data Element Usage
N201 0093 AN 1 35 M	Name Additional Submitter Name Free-form name.
N202 0093 AN 1 35 O	Name Additional Submitter Name Free-form name.

X12 Segment Name: N3 Address Information
Name: Submitter Address
Loop: 1000
Max. Use: 1
X12 Purpose: To specify the location of the named party
Usage: Optional
Example: N3*123 MAIN STREET~

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
N301 0166 AN 1 35 M	Address Information Submitter Address 1 Address information The mailing address of the submitter of the claim file.	01-10
N302 0166	Address Information Not Used.	

X12 Segment Name: N4 Geographic Location
Name: Submitter City, State, ZIP
Loop: 1000
Max. Use: 1
X12 Purpose: To specify the geographic place of the named party
Usage: Optional
Example: N4*ANY TOWN*TX*75123~

Syntax Note: C0605 - If N406 is present, then N405 must be present.

X12 Comment: A combination of either N401 through N404 (or N405 and N406) may be adequate to specify a location.
X12 Comment: N402 is required only if city name (N401) is in the USA or Canada.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
N401 0019 AN 2 30 O	City Name Submitter City Free-form text for city name. The city name of the submitter of the claim file.	01-11
N402 0156 ID 2 2 O	State or Province Code Submitter State Code (Standard State/Province) as defined by appropriate government agency.	01-12
N403 0116 ID 3 11 O	Postal Code Submitter ZIP Code Code defining international postal zone code excluding punctuation and blanks (zip code for United States). The ZIP code of the submitter of the claim file.	01-13
N404 0026 ID 2 3 O	Country Code Submitter Country Code Code identifying the country. The country in which the respective person or entity resides.	01-15
N405 0309	Location Qualifier Not Used.	
N406 0310	Location Identifier	

Not Used.

X12 Segment Name: PER Administrative Communications Contact
Name: Submitter Contact
Loop: 1000
Max. Use: 1
X12 Purpose: To identify a person or office to whom administrative communications should be directed
Usage: Optional
Example: PER*SM*JANE DOE*TE*2145551212~

Syntax Note: P0304 - If either PER03 or PER04 is present, then the other must be present.
Syntax Note: P0506 - If either PER05 or PER06 is present, then the other must be present.
Syntax Note: P0708 - If either PER07 or PER08 is present, then the other must be present.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
PER01 0366 ID 2 2 M	Contact Function Code Code identifying the major duty or responsibility of the person or group named. Codes: SM Submitting Contact	
PER02 0093 AN 1 35 M	Name Submitter Contact Free-form name. Identifies an individual responsible for issues that may arise concerning this submission. SUBMITTER NAME.	01-09
PER03 0365 ID 2 2 C	Communication Number Qualifier Code identifying the type of communication number. Codes: TE Telephone	
PER04 0364 AN 1 80 C	Communication Number Submitter Telephone Number Complete communications number including country or area code when applicable. The telephone number of the submitter of the claim file.	01-16
PER05 0365 ID 2 2 C	Communication Number Qualifier Code identifying the type of communication number. Codes:	

FX Facsimile

PER06 0364 AN 1 80 C	Communication Number Submitter Fax Number Complete communications number including country or area code when applicable. The Telefax number of the submitter of the claim file.	01-14
PER07 0365	Communication Number Qualifier Not Used.	
PER08 0364	Communication Number Not Used.	
PER09 0443	Contact Inquiry Reference Not Used.	

X12 Segment Name: PRV Provider Information
Name: Billing Provider
Loop: 2000
Max. Use: 1
X12 Purpose: To specify the identifying characteristics of a provider
Usage: Mandatory
Example: PRV*BI*1C*IM0345~
Comments: The Billing Provider is assumed to also be the Rendering Provider for all claims, unless overriden in loop 2310 by a NM101 containing code 82

Syntax Note: P0506 - If either PRV05 or PRV06 is present, then the other must be present.

Semantic Note: PRV05 qualifies PRV06.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
PRV01 1221 ID 1 3 M	Provider Code Code indentifying the type of provider Codes: BI Billing	
PRV02 0128 ID 2 2 M	Reference Number Qualifier Code qualifying the Reference Number. Codes: 1C Medicare Provider Number ZZ Mutually Defined (National Provider ID)	
PRV03 0127 AN 1 30 M	Reference Number Medicare Provider Number Reference number or identification number as defined for a particular Transaction Set, or as specified by the Reference Number Qualifier. The number assigned to the provider by the Medicare payor for Medicare identification purposes.	10-06, 30-24
PRV04 0156	State or Province Code Not Used.	
PRV05 0559	Agency Qualifier Code Not Used.	
PRV06 1222	Provider Specialty Code Not Used.	
PRV07 1223	Provider Organization Code	

Not Used.

X12 Segment Name: NM1 Individual or Organizational Name
Name: Billing Provider Name and ID
Loop: 2010
Max. Use: 1
X12 Purpose: To supply the full name of an individual or organizational entity
Usage: Conditional
Example: NM1*85*2*GOOD SAMARITAN~
Comments: When the Provider is identified by 2-005-PRV03, the entire loop 2010 may not be required. However, if any of the segments in the loop is needed, then NM1 must be present. The example above shows such a minimal NM1 segment to satisfy this syntax condition.

Syntax Note: P0809 - If either NM108 or NM109 is present, then the other must be present. --

Semantic Note: NM102 qualifies NM103.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
NM101 0098 ID 2 2 M	Entity Identifier Code Code identifying an organizational entity, a physical location, or an individual Codes: 85 Billing Provider	
NM102 1065 ID 1 1 M	Entity Type Qualifier Code qualifying the type of entity. Codes: 2 Non-Person Entity	
NM103 1035 AN 1 35 M	Name Last or Organization Name Provider Organization Name Individual last name or organizational name The name of the organization submitting a claim for payment. PROVIDER NAME.	10-12
NM104 1036	Name First Not Used.	
NM105 1037	Name Middle Not Used.	
NM106 1038	Name Prefix Not Used.	

NM107 1039	Name Suffix Not Used.	
NM108 0066 ID 1 2 C	Identification Code Qualifier Code designating the system/method of code structure used for Identification Code (67). Codes: FI Federal Taxpayer's Identification Number	
NM109 0067 AN 2 20 C	Identification Code Billing Provider Federal Tax Number Code identifying a party or other code. This field references the Tax ID or EIN and the Federal Tax Sub ID.	10-04, 10-05

X12 Segment Name: N2 Additional Name Information
Name: Billing provider Additional Name
Loop: 2010
Max. Use: 1
X12 Purpose: To specify additional names or those longer than 35 characters in length
Usage: Optional
Example: N2*LONG NAME~
Comments: This segment should be utilized only if NM103 is insufficient in size.

Element Attributes	Data Element Usage
N201 0093 AN 1 35 M	Name Billing provider Additional Name Free-form name.
N202 0093 AN 1 35 O	Name Billing provider Additional Name Free-form name.

X12 Segment Name: N3 Address Information
Name: Billing Provider Address
Loop: 2010
Max. Use: 1
X12 Purpose: To specify the location of the named party
Usage: Optional
Example: N3*35 W ELM ST*SUITE 101~

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
N301 0166 AN 1 35 M	Address Information Billing Provider Address 1 Address information The street address of the Provider.	10-13
N302 0166	Address Information Not Used.	

X12 Segment Name: N4 Geographic Location
Name: Billing Provider City, State, ZIP
Loop: 2010
Max. Use: 1
X12 Purpose: To specify the geographic place of the named party
Usage: Optional
Example: N4*ANY TOWN*TX*75124~

Syntax Note: C0605 - If N406 is present, then N405 must be present.

X12 Comment: A combination of either N401 through N404 (or N405 and N406) may be adequate to specify a location.
X12 Comment: N402 is required only if city name (N401) is in the USA or Canada.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
N401 0019 AN 2 30 O	City Name Provider City Free-form text for city name. The city name of the Provider.	10-14
N402 0156 ID 2 2 O	State or Province Code Provider State Code (Standard State/Province) as defined by appropriate government agency. See Section B for State Abbreviation Codes.	10-15
N403 0116 ID 3 11 O	Postal Code Provider ZIP Code defining international postal zone code excluding punctuation and blanks (zip code for United States). The ZIP code of the Provider.	10-16
N404 0026 ID 2 3 O	Country Code Code identifying the country.	10-18
N405 0309	Location Qualifier Not Used.	
N406 0310	Location Identifier Not Used.	

X12 Segment Name: PER Administrative Communications Contact
Name: Billing Provider Telephone Number
Loop: 2010
Max. Use: 1
X12 Purpose: To identify a person or office to whom administrative communications should be directed
Usage: Optional
Example: PER*PH**TE*8175551212~

Syntax Note: P0304 - If either PER03 or PER04 is present, then the other must be present.
Syntax Note: P0506 - If either PER05 or PER06 is present, then the other must be present. Syntax Note: P0708 - If either PER07 or PER08 is present, then the other must be present.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
PER01 0366 ID 2 2 M	Contact Function Code Code identifying the major duty or responsibility of the person or group named. Codes: PH Provider Entity providing health care services	
PER02 0093 AN 1 35 O	Name Billing Provider Contact Person Free-form name.	
PER03 0365 ID 2 2 C	Communication Number Qualifier Code identifying the type of communication number. Codes: TE Telephone	
PER04 0364 AN 1 80 C	Communication Number Billing Provider Telephone Number Complete communications number including country or area code when applicable. The telephone number, including area code at which the provider can be contacted.	10-11
PER05 0365 ID 2 2 C	Communication Number Qualifier Code identifying the type of communication number. Codes:	

FX Facsimile

PER06 0364 AN 1 80 C	Communication Number Billing Provider Fax Number Complete communications number including country or area code when applicable. The Telefax number, including area code at which the provider can be contacted.	10-17
PER07 0365	Communication Number Qualifier Not Used.	
PER08 0364	Communication Number Not Used.	
PER09 0443	Contact Inquiry Reference Not Used.	

X12 Segment Name: SBR Subscriber Information
Name: Medicare Primary / Secondary / Tertiary Indicator
Loop: 2100
Max. Use: 1
X12 Purpose: To record information specific to the primary insured and the insurance carrier for that insured
Purpose: To indicate whether Medicare is the primary, secondary, or tertiary payor.
Usage: Mandatory
Example: SBR*P********MA~
Comments: When Medicare is not the primary payor, loop 2320 must be used to supply information about the primary payor.

Semantic Note: SBR02 specifies the relationship to the person insured.
Semantic Note: SBR03 is policy or group number.
Semantic Note: SBR04 is plan name.
Semantic Note: SBR07 is destination payer code. A "Y" value indicates the payer is the destination payer. An "N" value indicates the payer is not the destination payer.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
SBR01 1138 ID 1 1 M	Payer Responsibility Sequence Number Code Medicare Responsibility Sequence Code Code identifying the insurance carrier's level of responsibility for a payment of a claim Code identifying Medicare's level of responsibility for payment of a claim. Codes: P Primary S Secondary T Tertiary	30-02 UB92 Code "1" UB92 Code "2" UB92 Code "3"
SBR02 1069	Individual Relationship Code Not Used.	
SBR03 0127	Reference Number Not Used.	
SBR04 0093	Name Not Used.	
SBR05 1336	Insurance Type Code Not Used.	
SBR06 1143	Coordination of Benefits Code Not Used.	

SBR07 1073 Yes/No Condition or Response Code
Not Used.

SBR08 0584 Employment Status Code
Not Used.

SBR09 1032 Claim Filing Indicator Code
ID 1 2 O Code identifying type of claim
Codes:
MA Medicare Part A

X12 Segment Name: PAT Patient Information
Loop: 2200
Max. Use: 1
X12 Purpose: To supply patient information
Usage: Mandatory
Example: PAT*18**RT~

Syntax Note: P0506 - If either PAT05 or PAT06 is present, then the other must be present.

Semantic Note: PAT06 is the date of death.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
PAT01 1069 ID 2 2 M	Individual Relationship Code Patient's Relationship to Insured Code indicating the relationship between two individuals or entities. Codes: 18 Self	30-18 UB92 Code "01"
PAT02 1384	Patient Location Code Not Used.	
PAT03 0584 ID 2 2 O	Employment Status Code Patient Employment Status Code Code showing the general employment status of an employee/claimant. A code indicating employment status of the patient. EMPLOYMENT STATUS CODE. Codes: (Not all codes map) AO Active Military - Overseas AU Active Military - USA FT Full-time NE Not Employed PT Part-time RT Retired SE Self-Employed UK Unknown	30-19 UB92 Code "1" UB92 Code "3" UB92 Code "2" UB92 Code "5" UB92 Code "4" UB92 Code "9"
PAT04 1220	Student Status Code Not Used.	
PAT05 1250	Date Time Period Format Qualifier Not Used.	
PAT06 1251	Date Time Period Not Used.	

PAT07 355 UNIT OR BASIS FOR MEASUREMENT CODE
Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken
Not Used

PAT08 81 WEIGHT
Numeric value of weight.
Not Used

X12 Segment Name: NM1 Individual or Organizational Name
Name: Patient Name and HICNO
Loop: 2210
Max. Use: 1
X12 Purpose: To supply the full name of an individual or organizational entity
Usage: Mandatory
Example: NM1*QC*1*JOE*JOHN****HN*123234567A~

Syntax Note: P0809 - If either NM108 or NM109 is present, then the other must be present.

Semantic Note: NM102 qualifies NM103.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
NM101 0098 ID 2 2 M	Entity Identifier Code Code identifying an organizational entity, a physical location, or an individual Codes: QC Patient Individual receiving medical care	
NM102 1065 ID 1 1 M	Entity Type Qualifier Code qualifying the type of entity. Codes: 1 Person	
NM103 1035 AN 1 35 M	Name Last or Organization Name Patient Last Name Individual last name or organizational name The last name of the individual to whom the services were provided.	20-04
NM104 1036 AN 1 25 M	Name First Patient First Name Individual first name. The first name of the individual to whom the services were provided.	20-05
NM105 1037 AN 1 25 O	Name Middle Patient Middle Initial Individual middle name or initial. The middle initial of the individual to whom the services were provided.	20-06
NM106 1038	Name Prefix	

Not Used.

NM107 1039 Name Suffix
Not Used.

NM108 0066 Identification Code Qualifier
ID 1 2 M Code designating the system/method of code structure used for Identification Code (67).
Codes:
HN Health Insurance Claim (HIC) Number
Unique number assigned to individual for submitting claims covered by Medicare benefits

NM109 0067 Identification Code 30-07
AN 2 20 M Health Insurance Claim Number
Code identifying a party or other code.
Patient's Medicare ID number, including suffix or prefix. Do NOT use hyphens.

X12 Segment Name: N3 Address Information
Name: Patient Address
Loop: 2210
Max. Use: 1
X12 Purpose: To specify the location of the named party
Usage: Mandatory
Example: N3*44 W 1500 SOUTH ST~

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
N301 0166 AN 1 35 M	Address Information Patient Address 1 Address information The mailing address of the patient.	20-12
N302 0166 AN 1 35 O	Address Information Patient Address 2 Address information Additional mailing address of the patient.	20-13

X12 Segment Name: N4 Geographic Location
Name: Patient City, State, ZIP
Loop: 2210
Max. Use: 1
X12 Purpose: To specify the geographic place of the named party
Usage: Mandatory
Example: N4*ANY TOWN*TX*75122~

Syntax Note: C0605 - If N406 is present, then N405 must be present.

X12 Comment: A combination of either N401 through N404 (or N405 and N406) may be adequate to specify a location.
X12 Comment: N402 is required only if city name (N401) is in the USA or Canada.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
N401 0019 AN 2 30 M	City Name Patient City Free-form text for city name. The City Name of the patient.	20-14
N402 0156 ID 2 2 M	State or Province Code Patient State Code (Standard State/Province) as defined by appropriate government agency. See Section B for State Abbreviation Codes.	20-15
N403 0116 ID 3 11 M	Postal Code Patient ZIP Code Code defining international postal zone code excluding punctuation and blanks (zip code for United States). The ZIP Code of the patient.	20-16
N404 0026	Country Code Not Used.	
N405 0309	Location Qualifier Not Used.	
N406 0310	Location Identifier Not Used.	

X12 Segment Name: DMG Demographic Information
Name: Patient Demographic Information
Loop: 2210
Max. Use: 1
X12 Purpose: To supply demographic information
Usage: Mandatory
Example: DMG*D8*19181105*M~

Syntax Note: P0102 - If either DMG01 or DMG02 is present, then the other must be present.

Semantic Note: DMG02 is the date of birth.
Semantic Note: DMG07 is the country of citizenship.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
DMG01 1250 ID 2 3 M	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format. Codes: **D8** Date Expressed in Format CCYYMMDD	
DMG02 1251 AN 1 35 M	Date Time Period Patient Date of Birth Expression of a date, a time, or range of dates, times or dates and times. The date the patient was born. DATE OF BIRTH.	20-08
DMG03 1068 ID 1 1 M	Gender Code Patient Sex Code Code indicating the sex of the individual. Code indicating the sex of the patient. Codes: F - Female, M - Male, U - Unknown	20-07
DMG04 1067 ID 1 1 O	Marital Status Code Patient Marital Status Code defining the marital status of a person. Codes: I Single M Married D Divorced S Separated K Unknown W Widowed	20-09 UB-92 Code "S" UB-92 Code "M" UB-92 Code "D" UB-92 Code "X" UB-92 Code "U" UB-92 Code "W"

DMG05 1109 Race or Ethnicity Code
Not Used.

DMG06 1066 Citizenship Status Code
Not Used.

DMG07 0026 Country Code
Not Used.

DMG08 0659 Basis of Verification Code
Not Used.

X12 Segment Name: REF Reference Numbers
Name: Medical Record Number
Loop: 2210
Max. Use: 1
X12 Purpose: To specify identifying numbers.
Usage: Optional
Example: REF*EA*9300456~

Syntax Note: R0203 - At least one of REF02 or REF03 must be present.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
REF01 0128 ID 2 2 M	Reference Number Qualifier Code qualifying the Reference Number. Codes: **EA** Medical Record Identification Number A unique number assigned to each patient by the provider of service (hospital) to assist in retrieval of medical records	
REF02 0127 AN 1 30 C	Reference Number Medical Record Number Reference number or identification number as defined for a particular Transaction Set, or as specified by the Reference Number Qualifier.	20-25
REF03 0352	Description Not Used.	

X12 Segment Name: CLM Health Claim
Loop: 2300
Max. Use: 1
X12 Purpose: To specify basic data about the claim
Usage: Mandatory
Example: CLM*DOJ 023479 1*25.25*MA**A:11:1***Y*Y~

Semantic Note: CLM02 is the total amount of all submitted charges of service segments for this claim.
Semantic Note: CLM06 is provider signature on file indicator. A "Y" value indicates the provider signature is on file. An "N" value indicates the provider signature is not on file.
Semantic Note: CLM08 is assignment of benefits indicator. A "Y" value indicates insured or authorized person authorizes benefits to be assigned to the provider. An "N" value indicates benefits have not been assigned to the provider.
Semantic Note: CLM13 is CHAMPUS non-availability indicator. A "Y" value indicates a statement of non-availability is on file. An "N" value indicates statement of non-availability is not on file or not necessary.
Semantic Note: CLM15 is charges itemized by service indicator. A "Y" value indicates charges are itemized by service. An "N" value indicates charges are summarized by service.
Semantic Note: CLM18 is explanation of benefit (EOB) indicator. A "Y" value indicates that a paper EOB is requested. An "N" value indicates that no paper EOB is requested.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
CLM01 1028 AN 1 38 M	Claim Submitter's Identifier Patient Control Number Identifier used to track a claim from creation by the health care provider through payment. A unique value assigned by the provider to identify the patient.	20-03 through 91-03
CLM02 0782 R 1 15 M	Monetary Amount Total Claim Charges Monetary amount. This is the total of the SV2 segments with the exception of revenue code 001. Non-covered accommodations and non-covered ancillaries are not reflected in this element.	Total of 90-13 and 90-15
CLM03 1032 ID 1 2 M	Claim Filing Indicator Code Claim Editing Indicator Code identifying type of claim A code assigned by the receiver to determine the adjudication program. Codes:	30-04

MA Medicare Part A UB92 Code "C"

CLM04 1343 Non-Institutional Claim Type Code
Not Used.

CLM05 C023 Health Care Service Location Information
Composit O Type of Bill
To provide information that identifies the place of service or the type of bill related to the location at which a health care service was rendered

*-01 1331 Facility Code Value 40-04
AN 1 2 M Type of Bill Positions 1-2
Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format FIRST 2 POSITIONS OF 3 POSITION FIELD

*-02 1332 Facility Code Qualifier
ID 1 2 O Code identifying the type of facility referenced
See UB-92 Bill Types
Codes:
A Uniform Billing Claim Form Bill Type

*-03 1325 Claim Frequency Type Code 40-04
ID 1 1 O Type of Bill Position 3
Code specifying the frequency of the claim; this is the third position of the Uniform Billing Claim Form Bill Type THIRD POSITION OF 3 POSITION FIELD

CLM06 1073 Yes/No Condition or Response Code
Not Used.

CLM07 1359 Provider Accept Assignment Code
Not Used.

CLM08 1073 Yes/No Condition or Response Code 30-17
ID 1 1 M Assignment of Benefits Indicator
Code indicating a Yes or No condition or response.
A "Y" value indicates benefits are assigned to the provider.
A "N" indicates benefits are not

assigned to the provider.
Codes:
Y Yes
N No

CLM09 1363 Release of Information Code 30-16
ID 1 1 O Release of Information Code
Code indicating whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations
A code indicating whether the provider has on file a signed statement permitting the release of medical data to other organizations in order to adjudicate the claim.
Codes:

M The Provider has Limited or Restricted Ability to Release Data Related to a Claim	UB-92 CODE R=M
N No, Provider is Not Allowed to Release Data	UB-92 CODE N=N
Y Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim	UB-92 CODE Y=Y

CLM10 1351 Patient Signature Source Code
Not Used.

CLM11 C024 Related Causes Information
Not Used.

CLM12 1366 Special Program Code
Not Used.

CLM13 1073 Yes/No Condition or Response Code
Not Used.

CLM14 1338 Level of Service Code
Not Used.

CLM15 1073 Yes/No Condition or Response Code
Not Used.

CLM16 1360 Provider Agreement Code
Not Used.

CLM17 1029 Claim Status Code
Not Used.

CLM18 1073 Yes/No Condition or Response Code
Not Used.

CLM19 1383 Claim Submission Reason Code
Not Used.

CLM20 1514 Delay Reason Code
Not Used.

X12 Segment Name: **DTP Date or Time or Period**
Name: **Statement Covers Period**
Loop: 2300
Max. Use: 2
X12 Purpose: To specify any or all of a date, a time, or a time period.
Usage: **Required**
Examples: DTP*232*D8*19970217~
DTP*233*D8*19970218~
Comments: This segment is for the service date or for the service from and through dates.

Semantic Note: DTP02 identifies the date or time or period **format** that will appear in DTP03.

Element Attributes	Data Element Usage	**UB92 EMC VER.5.0 Mapping**
DTP01 0374 ID 3 3 M	Date/Time Qualifier Code specifying type of date or time, or both date and time. Codes (**Both are required - use this segment twice**): **232 Claim Statement Period Start** **233 Claim Statement Period End**	
DTP02 1250 ID 2 3 M	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format. Codes: **D8 Date expressed in format CCYYMMDD**	
DTP03 1251 AN 1 35 M	Date Time Period Expression of a date or time	(Start) **20-19, 9(8) CCYYMMDD** (End) **20-20, 9(8) CCYYMMDD**

X12 Segment Name: **DTP Date or Time or Period**
Name: **Admission Date (Inpatient Admission Date)**
Loop: 2300
Max. Use: 2
X12 Purpose: To specify any or all of a date, a time, or a time period.
Usage: **Conditional**
Example: DTP*435*D8*19970217~
Comments: **This segment may repeat twice, once for each date or time to convey.**

Semantic Note: DTP02 is the date or time or period format that will appear in DTP03.

Element Attributes	Data Element Usage	**UB92 EMC VER.5.0 Mapping**
DTP01 0374 ID 3 3 M	Date/Time Qualifier Code specifying type of date or time, or both date and time. Code: **435 Admission**	
DTP02 1250 ID 2 3 M	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format. Codes: **D8 Date expressed in Format CCYYMMDD** **TM Time expressed in Format HHMM (based on a 24 hour clock)**	
DTP03 1251 AN 1 35 M	Date Time Period **Admission Date/Admission Hour** Expression of a date or time Note: Admission hour is not used for Medicare but is carried for secondary insurance purposes.	(Hour) **20-17** (Date) **20-18, 9(8) CCYYMMDD**

X12 Segment Name: DTP Date or Time or Period
Name: Discharge Date/Hour
Loop: 2300
Max. Use: 2
X12 Purpose: To specify any or all of a date, a time, or a time period
Usage: Optional
Example: DTP*096*TM*1020~
Comments: This segment may repeat twice, once for each date or time to convey.

Semantic Note: DTP02 is the date or time or period format that will appear in DTP03.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
DTP01 0374 ID 3 3 M	Date/Time Qualifier Code specifying type of date or time, or both date and time. Codes: **096** Discharge	
DTP02 1250 ID 2 3 M	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format. Codes: **TM** Time Expressed in Format HHMM Time expressed in the format HHMM where HH is the numerical expression of hours in the day based on a twenty-four hour clock and MM is the numerical expression of minutes within an hour	
DTP03 1251 AN 1 35 M	Date Time Period Discharge Date/Hour Expression of a date, a time, or range of dates, times or dates and times.	20-22

X12 Segment Name: **DTP Date or Time or Period**
Name: **Start of Care (SOC) Date (NOT used for Inpatient Admission)**
Loop: 2300
Max. Use: 1
X12 Purpose: To specify any or all of a date, a time, or a time period.
Usage: **Conditional**
Examples: DTP*454*D8*19970217~

Semantic Note: DTP02 identifies the date or time or period **format** that will appear in DTP03.
Medicare Note: The date in this segment is required if CR602 in the CR6 segment is used. It expresses the date in a millennium compliant format that occurs in a 6 digit format in CR602.

Element Attributes	Data Element Usage	**UB92 EMC VER.5.0 Mapping**
DTP01 0374 ID 3 3 M	Date/Time Qualifier Code specifying type of date or time, or both date and time. Code: **454** **Initial Treatment -** Date medical treatment first began	
DTP02 1250 ID 2 3 M	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format. Codes: **D8** **Date expressed in format CCYYMMDD**	
DTP03 1251 AN 1 35 M	Date Time Period Expression of a date or time	**71-05 CCYYMMDD**

X12 Segment Name: **DTP Date or Time or Period**
Name: **Date of Onset or Exacerbation of Principle Diagnosis**
Loop: 2300
Max. Use: 1
X12 Purpose: To specify any or all of a date, a time, or a time period.
Usage: **Optional**
Examples: DTP*431*D8*19970217~

Semantic Note: DTP02 identifies the date or time or period **format** that will appear in DTP03.

Element Attributes	Data Element Usage	**UB92 EMC VER.5.0 Mapping**
DTP01 0374 ID 3 3 M	Date/Time Qualifier Code specifying type of date or time, or both date and time. Code: **431 Onset of Current Symptoms or Illness** - Date first symptoms appeared	
DTP02 1250 ID 2 3 M	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format. Codes: **D8 Date expressed in format CCYYMMDD**	
DTP03 1251 AN 1 35 M	Date Time Period Expression of a date or time	**71-08 CCYYMMDD**

X12 Segment Name: **DTP Date or Time or Period**
Name: **Date of Surgery**
Loop: 2300
Max. Use: 1
X12 Purpose: To specify any or all of a date, a time, or a time period.
Usage: **Conditional**
Examples: DTP*456*D8*19970217~

Semantic Note: DTP02 identifies the date or time or period **format** that will appear in DTP03.
Medicare Note: The date in this segment is required if CR609 in the CR6 segment is used. It expresses the date in a millennium compliant format that occurs in a 6 digit format in CR609.

Element Attributes	Data Element Usage	**UB92 EMC VER.5.0 Mapping**
DTP01 0374 ID 3 3 M	Date/Time Qualifier Code specifying type of date or time, or both date and time. Code: **456** **Surgery -** Date on which operation was performed	
DTP02 1250 ID 2 3 M	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format. Codes: **D8** **Date expressed in format CCYYMMDD**	
DTP03 1251 AN 1 35 M	Date Time Period Expression of a date or time	**71-10**

X12 Segment Name: **DTP Date or Time or Period**
Name: **Last Seen Date**
Loop: 2300
Max. Use: 1
X12 Purpose: To specify any or all of a date, a time, or a time period.
Usage: **Optional**
Examples: DTP*304*D8*19970217~

Semantic Note: DTP02 identifies the date or time or period **format** that will appear in DTP03.

Element Attributes	Data Element Usage	**UB92 EMC VER.5.0 Mapping**
DTP01 0374 ID 3 3 M	Date/Time Qualifier Code specifying type of date or time, or both date and time. Code: **304** **Latest Visit or Consultation -** Date Subscriber or dependent last visited or consulted with a physician	
DTP02 1250 ID 2 3 M	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format. Codes: **D8** **Date expressed in format CCYYMMDD**	
DTP03 1251 AN 1 35 M	Date Time Period Expression of a date or time	**71-23**

X12 Segment Name: **DTP Date or Time or Period**
Name: **Verbal Start of Care (SOC) Date**
Loop: 2300
Max. Use: 1
X12 Purpose: To specify any or all of a date, a time, or a time period.
Usage: **Optional**
Examples: DTP*150*D8*19970217~

Semantic Note: DTP02 identifies the date or time or period **format** that will appear in DTP03.

Element Attributes	Data Element Usage	**UB92 EMC VER.5.0 Mapping**
DTP01 0374 ID 3 3 M	Date/Time Qualifier Code specifying type of date or time, or both date and time. Code: **150 Service Period Start**	
DTP02 1250 ID 2 3 M	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format. Codes: **D8 Date expressed in format CCYYMMDD**	
DTP03 1251 AN 1 35 M	Date Time Period Expression of a date or time	**71-17**

X12 Segment Name: **DTP Date or Time or Period**
Name: **Date of Secondary Diagnosis - 1**
Loop: 2300
Max. Use: 1
X12 Purpose: To specify any or all of a date, a time, or a time period.
Usage: **Optional**
Examples: DTP*438*D8*19970217~

Semantic Note: DTP02 identifies the date or time or period **format** that will appear in DTP03.

Element Attributes	Data Element Usage	**UB92 EMC VER.5.0 Mapping**
DTP01 0374 ID 3 3 M	Date/Time Qualifier Code specifying type of date or time, or both date and time. Code: **438 Onset of Similar Symptoms or Illness** - Date symptoms related to current illness first appeared	
DTP02 1250 ID 2 3 M	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format. Codes: **D8 Date expressed in format CCYYMMDD**	
DTP03 1251 AN 1 35 M	Date Time Period Expression of a date or time	**71-11**

X12 Segment Name: **DTP Date or Time or Period**
Name: **Date of Secondary Diagnosis - 2**
Loop: 2300
Max. Use: 1
X12 Purpose: To specify any or all of a date, a time, or a time period.
Usage: **Optional**
Examples: DTP*447*D8*19970217~

Semantic Note: DTP02 identifies the date or time or period **format** that will appear in DTP03.

Element Attributes	Data Element Usage	**UB92 EMC VER.5.0 Mapping**
DTP01 0374 ID 3 3 M	Date/Time Qualifier Code specifying type of date or time, or both date and time. Code: **447** **Occurrence** - Date on which an event happened	
DTP02 1250 ID 2 3 M	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format. Codes: **D8** **Date expressed in format CCYYMMDD**	
DTP03 1251 AN 1 35 M	Date Time Period Expression of a date or time	**71-12**

X12 Segment Name: **DTP Date or Time or Period**
Name: **Date Physician Last Contacted Patient**
Loop: 2300
Max. Use: 1
X12 Purpose: To specify any or all of a date, a time, or a time period.
Usage: **Optional**
Examples: DTP*911*D8*19970217~

Semantic Note: DTP02 identifies the date or time or period **format** that will appear in DTP03.

Element Attributes	Data Element Usage	**UB92 EMC VER.5.0 Mapping**
DTP01 0374 ID 3 3 M	Date/Time Qualifier Code specifying type of date or time, or both date and time. Code: **911 Last Activity**	
DTP02 1250 ID 2 3 M	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format. Codes: **D8 Date expressed in format CCYYMMDD**	
DTP03 1251 AN 1 35 M	Date Time Period Expression of a date or time	**71-24**

X12 Segment Name: CL1 Claim Codes
Loop: 2300
Max. Use: 1
X12 Purpose: To supply information specific to hospital claims
Usage: Conditional
Example: CL1*3*2*30~
Comments: CL101-103 is required for inpatient claims.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
CL101 1315 ID 1 1 O	Admission Type Code Code indicating the priority of this admission	20-10
CL102 1314 ID 1 1 O	Admission Source Code Code indicating the source of this admission	20-11
CL103 1352 ID 1 2 O	Patient Status Code Code indicating patient status as of the "statement covers through date"	20-21
CL104 1345	Nursing Home Residential Status Code Not Used.	

X12 Segment Name: AMT Monetary Amount
Name: Patient Amount Paid
Loop: 2300
Max. Use: 1
X12 Purpose: To indicate the total monetary amount.
Usage: Optional
Example: AMT*F5*5.25~

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
AMT01 0522 ID 1 2 M	Amount Qualifier Code Code to qualify amount Codes: **F5** Patient Amount Paid Monetary amount value already paid by one receiving medical care	
AMT02 0782 R 1 15 M	Monetary Amount Patient Amount Paid Monetary amount. The amount the provider has received from the patient (or insured) toward payment of this claim. PAYMENTS RECEIVED.	20-23
AMT03 0478	Credit/Debit Flag Code Not Used.	

X12 Segment Name: AMT Monetary Amount
Name: Patient Balance Due
Loop: 2300
Max. Use: 1
X12 Purpose: To indicate the total monetary amount.
Usage: Optional
Example: AMT*F3*3.2~

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
AMT01 0522 ID 1 2 C	Amount Qualifier Code Code to qualify amount Codes: **F3** Patient Responsibility - Estimated Approximate value one receiving medical care is obliged to pay	
AMT02 0782 R 1 15 C	Monetary Amount Patient Balance Due Monetary amount. Amount of total charges remaining if partial payment is made by the patient. ESTIMATED AMOUNT DUE.	20-24
AMT03 0478	Credit/Debit Flag Code Not Used.	

X12 Segment Name: REF Reference Numbers
Name: Original ICN/DCN Number
Loop: 2300
Max. Use: 1
X12 Purpose: To specify identifying numbers.
Usage: Optional
Example: REF*F8*931278760100~

Syntax Note: R0203 - At least one of REF02 or REF03 must be present.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
REF01 0128 ID 2 2 M	Reference Number Qualifier Code qualifying the Reference Number. Codes: **F8** Original Reference Number	
REF02 0127 AN 1 30 C	Reference Number Original ICN/DCN Number Reference number or identification number as defined for a particular Transaction Set, or as specified by the Reference Number Qualifier.	31-14
REF03 0352	Description Not Used.	

```
  SEGMENT: REF Reference Numbers
     NAME: INVESTIGATIONAL DEVICE EXPANSION NUMBER
 POSITION: 180
    LEVEL: Detail
     LOOP: 2300
    USAGE: Optional
  MAX USE: 5
  PURPOSE: To specify identifying numbers.
  EXAMPLE: REF*LX*12345~
   SYNTAX:  1. R0203--At least one of REF02 or REF03 is required.
    NOTES:  1. Map the data from the Medicare occurrence of the 34 record
               only.
            2. The authorization number will only be an IDE number if the
               corresponding authorization revenue code is equal to 0624.
               If the authorization number is not an IDE number, then it
               should not be mapped

DATA ELEMENT SUMMARY ------------------------------------------------

REF01 128  REFERENCE NUMBER QUALIFIER                          M ID 2/3
           Code qualifying the Reference Number.
               LX Qualified Products List
REF02 127  REFERENCE NUMBER                                    M AN 1/30
           Reference number or identification number as defined for a
           particular Transaction Set, or as specified by the Reference
           Number Qualifier.
           IDE Code
           34-5 ; 34-10; 34-11
REF03 352  DESCRIPTION                                         C AN 1/80
           A free-form description to clarify the related data elements
           and their content.
           Not Used
```

X12 Segment Name: REF Reference Numbers
Name: Data ID
Loop: 2300
Max. Use: 1
X12 Purpose: To specify identifying numbers.
Usage: Optional
Example: REF*DD*9~

Syntax Note: R0203 - At least one of REF02 or REF03 must be present.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
REF01 0128 ID 2 2 M	Reference Number Qualifier Code qualifying the Reference Number. Codes: **DD** Document Identification Code	
REF02 0127 AN 1 30 M	Reference Number Data ID Reference number or identification number as defined for a particular Transaction Set, or as specified by the Reference Number Qualifier. Identifies the submission of 485 and 486 data or 486 data only.	71-4
REF03 0352	Description Not Used.	

X12 Segment Name: NTE Note/Special Instruction
Name: Billing Remarks
Loop: 2300
Max. Use: 20
X12 Purpose: To transmit information in a free-form format, if necessary, for comment or special instruction
Usage: Optional
Example: NTE*ADD*No liability, patient fell at home~
Comments: Medical attachment information, like ambulance, therapy codes, or other additional information.

X12 Comment: The NTE segment permits free-form information/data which, under ANSI X12 standard implementations, is not machine processable. The use of the "NTE" segment should therefore be avoided, if at all possible, in an automated environment.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
NTE01 0363 ID 3 3 O	Note Reference Code Code identifying the functional area or purpose for which the note applies. Codes: **ADD** Additional Information	
NTE02 0352 AN 1 80 M	Description Billing Remarks A free-form description to clarify the related data elements and their content. When translating from 837 to UB-92, generating RT 91 Remarks, generate a "1" in the 90-12 field.	90-17, 91-04

X12 Segment Name: NTE Note/Special Instruction
Name: Home Health Corresponding Data
Loop: 2300
Max. Use: 20
X12 Purpose: To transmit information in a free-form format, if necessary, for comment or special instruction
Usage: Optional
Example: NTE*NTR*PATIENT REQUIRES TUBE FEEDING~
Comments: Medical attachment information, like home health update narrative.

X12 Comment: The NTE segment permits free-form information/data which, under ANSI X12 standard implementations, is not machine processable. The use of the "NTE" segment should therefore be avoided, if at all possible, in an automated environment.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
NTE01 0363 ID 3 3 O	Note Reference Code Code identifying the functional area or purpose for which the note applies. Codes: (See UB-92 Specifications for applicable codes) **MED** Medications **DME** Durable Medical Equipment (DME) and Supplies **SFM** Safety Measures **NTR** Nutritional Requirements **ALG** Allergies **ODT** Orders for Disciplines and Treatments **DCP** Goals, Rehabilitation Potential, or Discharge Plans **UPI** Updated Information **RHB** Functional Limitations, Reason Homebound, or Both **SPT** Supplementary Plan of Treatment **SET** Unusual Home, Social Environment, or Both **RNH** Times and Reasons Patient Not at Home **RLH** Reasons Patient Leaves Home	73-5
NTE02 0352 AN 1 80 M	Description Corresponding Data A free-form description to clarify the related data elements and their content. Generate only when generating home health medical update narrative attachment. If more than	73-6

one code applies, repeat the segment.

X12 Segment Name: **CR6 Home Health Care Certification**
Loop: 2300
Max. Use: 1
X12 Purpose: To supply information related to the certification of a home health care patient
Usage: **Optional** (Recommended for Home Health claims)
Example: CR6*1*980413*RD8*19980301-19980331**N*Y*R~

Syntax Note: P0304 - If either CR603 or CR604 is present, then the other must be present.
Syntax Note: P091011 - If either CR609, CR610 or CR611 are present, then the others are required.
Syntax Note: P151617 - If either CR615, CR616 or CR617 are present, then the others are required.

Semantic Note: CR602 is the date covered home health services began.
Semantic Note: CR604 is the certification period covered by this plan of treatment.
Semantic Note: A "Y" value indicates patient is receiving care in a 1861J1 (skilled nursing) facility. An "N" value indicates patient is not receiving care in a 1861J1 facility. A "U" value indicates it is unknown whether or not the patient is receiving care in a 1861J1 facility.
Semantic Note: A "Y" value indicates the patient is covered by Medicare. An "N" - not covered by Medicare.
Semantic Note: CR610 qualifies CR611.
Semantic Note: CR611 is the surgical procedure most relevant to the care being rendered.
Semantic Note: CR616 is the date range of the most recent inpatient stay.
Semantic Note: CR617 indicates the type of facility from which the patient was most recently discharged.

Element Attributes	Data Element Usage	**UB92 EMC VER.5.0 Mapping**
CR601 0923 ID 1 1 M	Prognosis Code Code indicating physician's prognosis for the patient Codes: 1 - Poor 2 - Guarded 3 - Fair 4 - Good 5 - Very Good 6 - Excellent 7 - Less than 6 Months to Live 8 - Terminal	**71-16**
CR602 0373 DT 6 6 M	Date Date (YYMMDD) SOC Date **Medicare Note: This duplicates the SOC date in the DTP segment. Do NOT process CR602 data. Process the SOC date in its corresponding DTP segment (to comply with millennium requirements). The 6 digit SOC date is duplicated here to comply with X12 standards.**	**71-5 CCYYMMDD**
CR603 1250 ID 2 3 C	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format. Codes: **RD8** Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD	

CR604 1251
AN 1 35 M
Date Time Period
Certification Period **71-6,7 CCYYMMDD**
Expression of a date or time

CR605 0373
Date
Not Used.

CR606 1073
ID 1 1 O
Yes/No Condition or Response Code
Patient Receiving Care in 1861(j)(1) **71-25**
Facility Code indicating a Yes or No condition or response.

Codes:

N - No	N - NO
U - Unknown	D - DO NOT KNOW
Y - Yes	Y - YES

CR607 1073
ID 1 1 M
Yes/No Condition or Response Code
Medicare Covered Code indicating a Yes or No condition or response. **71-22**
Codes:
N - No
Y - Yes

CR608 1322
ID 1 1 M
Certification Type Code
Cert/Recert/Mod **71-26**
Code indicating the type of certification
Codes:

I - Initial	C - CERTIFICATION
R - Renewal	R - RECERTIFICATION
S - Revised	M - MODIFIED

CR609 0373
DT 6 6 C
Date
Date (YYMMDD) **71-10 CCYYMMDD**
Date Surgical Procedure Performed
Medicare Note: This duplicates the surgery date in the DTP segment. Do NOT process CR609 data. Process the surgery date in its corresponding DTP segment (to comply with millennium requirements). The 6 digit surgery date is duplicated here to comply with X12 standards.

CR610 0235
ID 2 2 C
Product/Service ID Qualifier
Code identifying the type/source of the descriptive number used in Product/Service ID (234).
Codes:
ID - International Classification of Diseases Clinical Modification (ICD-9-CM)

CR611 1137
AN 1 15 C
Medical Code Value
Surgical Procedure Code **71-9**
Code value for describing a medical condition or procedure

CR612 0373
Date
Not Used.

CR613 0373
Date
Not Used.

CR614 0373
Date
Not Used.

CR615 1250
ID 2 3 C
Date Time Period Format Qualifier
Code indicating the date format, time format, or date and time format.

Codes:

RD8 Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD

CR616 1251
AN 1 35 C
Date Time Period
Date range of the most recent inpatient stay
Expression of a date, a time, or range of dates, times or dates and times.
71-27,28
CCYYMMDD

CR617 1384
ID 1 1 C
Patient Location Code
Type of Facility
Code identifying the location where patient is receiving medical treatment
For Medicare, type of facility from which patient was most recently discharged.
71-29

Codes:

A - Acute Care Facility	A - ACUTE
D - Intermediate Care Facility	I - ICF
L - Other Location	L - OTHER
M - Rehabilitation Facility	R - REHAB FACILITY
S - Skilled Nursing Home (SNF)	S - SNF

CR618 0373
Date
Not Used.

CR619 0373
Date
Not Used.

CR620 0373 Date
Not Used.

CR621 0373 Date
Not Used.

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X12 Segment Name: CRC Conditions Indicator
Name: Home Health Functional Limitations
Loop: 2300
Max. Use: 3
X12 Purpose: To supply information on conditions
Usage: Optional
Example: CRC*75*Y*AL~
Comments: Use only if creating the UB-92 Record 71 attachment.

Semantic Note: CRC01 qualifies CRC03 thru CRC07.
Semantic Note: CRC02 is a Certification Condition Code applies indicator. A `Y' value indicates the condition codes in CRC03 thru CRC07 apply. A `N' value indicates the condition codes in CRC03 thru CRC07 do not apply.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
CRC01 1136 ID 2 2 M	Code Category Specifies the situation or category the code applies to Codes: **75** Functional Limitations	
CRC02 1073 ID 1 1 M	Yes/No Condition or Response Code Conditions Apply / Do Not Apply Code indicating a Yes or No condition or response. Codes: Y Yes N No	
CRC03 1321 ID 2 2 M	Condition Indicator Code indicating a condition Codes reported in CRC04-07 Codes:	71-13
	AA Amputation	UB-92 Code 1
	BL Bowel Limitations, Bladder Limitations, or both (Incontinence)	UB-92 Code 2
	CO Contracture	UB-92 Code 3
	HL Hearing Limitations	UB-92 Code 4
	EL Endurance Limitations	UB-92 Code 6
	AL Ambulation Limitations	UB-92 Code 7
	PA Paralysis	UB-92 Code 5
	LB Legally Blind	UB-92 Code 9
	DY Dyspnea with Minimal Exertion	UB-92 Code A
	OL Other Limitation	UB-92 Code B

SL Speech Limitations UB-92 Code 8

CRC04 1321 Condition Indicator
ID 2 2 O Code indicating a condition
SEE CRC03 FOR VALID CODES
Codes:

CRC05 1321 Condition Indicator
ID 2 2 O Code indicating a condition
SEE CRC03 FOR VALID CODES
Codes:

CRC06 1321 Condition Indicator
ID 2 2 O Code indicating a condition
SEE CRC03 FOR VALID CODES
Codes:

CRC07 1321 Condition Indicator
ID 2 2 O Code indicating a condition
SEE CRC03 FOR VALID CODES
Codes:

X12 Segment Name: CRC Conditions Indicator
Name: Home Health Activities Permitted
Loop: 2300
Max. Use: 3
X12 Purpose: To supply information on conditions
Usage: Optional
Example: CRC*76*Y*CB~
Comments: Use only if creating the UB-92 Record 71 attachment.

Semantic Note: CRC01 qualifies CRC03 thru CRC07.
Semantic Note: CRC02 is a Certification Condition Code applies indicator. A `Y' value indicates the condition codes in CRC03 thru CRC07 apply. A `N' value indicates the condition codes in CRC03 thru CRC07 do not apply.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
CRC01 1136 ID 2 2 M	Code Category Specifies the situation or category the code applies to Codes: **76** Activities Permitted	
CRC02 1073 ID 1 1 M	Yes/No Condition or Response Code Conditions Apply / Do Not Apply Code indicating a Yes or No condition or response. Codes: Y Yes N No	
CRC03 1321 ID 2 2 M	Condition Indicator Code indicating a condition Codes reported in CRC04-07 Codes:	71-14
	CB Complete Bedrest	UB-92 Code 1
	BR Bedrest BRP (Bathroom Privileges)	UB-92 Code 2
	UT Up as Tolerated	UB-92 Code 3
	TR Transfer to Bed, or Chair, or Both	UB-92 Code 4
	EP Exercises Prescribed	UB-92 Code 5
	PW Partial Weight Bearing	UB-92 Code 6
	IH Independent at Home	UB-92 Code 7
	CR Crutches Required	UB-92 Code 8
	CA Cane Required	UB-92 Code 9
	WR Wheelchair Required	UB-92 Code A
	WA Walker Required	UB-92 Code B
	NR No Restrictions	UB-92 Code C
	OR Other Restrictions	UB-92 Code D

CRC04 1321 Condition Indicator
ID 2 2 O Code indicating a condition
SEE CRC03 FOR VALID CODES
Codes:

CRC05 1321 Condition Indicator
ID 2 2 O Code indicating a condition
SEE CRC03 FOR VALID CODES
Codes:

CRC06 1321 Condition Indicator
ID 2 2 O Code indicating a condition
SEE CRC03 FOR VALID CODES
Codes:

CRC07 1321 Condition Indicator
ID 2 2 O Code indicating a condition
SEE CRC03 FOR VALID CODES
Codes:

X12 Segment Name: CRC Conditions Indicator
Name: Home Health Mental Status
Loop: 2300
Max. Use: 3
X12 Purpose: To supply information on conditions
Usage: Optional
Example: CRC*77*Y*DI~
Comments: Use only if creating the UB-92 Record 71 attachment.

Semantic Note: CRC01 qualifies CRC03 thru CRC07.
Semantic Note: CRC02 is a Certification Condition Code applies indicator. A `Y' value indicates the condition codes in CRC03 thru CRC07 apply. A `N' value indicates the condition codes in CRC03 thru CRC07 do not apply.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
CRC01 1136 ID 2 2 M	Code Category Specifies the situation or category the code applies to Codes: **77** Mental Status	
CRC02 1073 ID 1 1 M	Yes/No Condition or Response Code Conditions Apply / Do Not Apply Code indicating a Yes or No condition or response. Codes: Y Yes N No	
CRC03 1321 ID 2 2 M	Condition Indicator Code indicating a condition Codes reported in CRC04-07 Codes:	71-15
	OT Oriented	UB-92 Code 1
	CM Comatose	UB-92 Code 2
	FO Forgetful	UB-92 Code 3
	DP Depressed	UB-92 Code 4
	DI Disoriented	UB-92 Code 5
	LE Lethargic	UB-92 Code 6
	AG Agitated	UB-92 Code 7
	MC Other Mental Condition	UB-92 Code 8
CRC04 1321 ID 2 2 O	Condition Indicator Code indicating a condition SEE CRC03 FOR VALID CODES Codes:	

CRC05 1321 Condition Indicator
ID 2 2 O Code indicating a condition
SEE CRC03 FOR VALID CODES
Codes:

CRC06 1321 Condition Indicator
ID 2 2 O Code indicating a condition
SEE CRC03 FOR VALID CODES
Codes:

CRC07 1321 Condition Indicator
ID 2 2 O Code indicating a condition
SEE CRC03 FOR VALID CODES
Codes:

X12 Segment Name: HI Health Care Information Codes
Loop: 2300
Max. Use: 25
X12 Purpose: To supply information related to the delivery of healthcare
Usage: Optional
Example: HI*BJ:3420*BK:436*BF:25000*BF:12345~

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
HI01 C022 Composit M	Health Care Code Information Health Care Code Information To send health care codes and their associated dates, amounts and quantities	
*-01 1270 ID 1 3 M	Code List Qualifier Code Health Care Codes Code identifying a specific industry code list Codes: **BJ** Admitting Diagnosis	
*-02 1271 AN 1 20 M	Industry Code Admitting Diagnosis Code Code indicating a code from a specific industry code list An ICD-9-CM Diagnosis Code identifying the admitting diagnosis. Do not include the period.	70-25
*-03 1250	Date Time Period Format Qualifier Not Used.	
*-04 1251	Date Time Period Not Used.	
*-05 0782	Monetary Amount Not Used.	
*-06 0380	Quantity Not Used.	
HI02 C022 Composit O	Health Care Code Information Health Care Code Information To send health care codes and their associated dates, amounts and quantities	

*-01 1270 Code List Qualifier Code
ID 1 3 M Health Care Codes
Code identifying a specific industry code list
Codes:
BK Principal Diagnosis

*-02 1271 Industry Code 70-04
AN 1 20 M Principle Diagnosis Code
Code indicating a code from a specific industry code list
An ICD-9-CM Diagnosis Code identifying the principal diagnosis.

*-03 1250 Date Time Period Format Qualifier
Not Used.

*-04 1251 Date Time Period
Not Used.

*-05 0782 Monetary Amount
Not Used.

*-06 0380 Quantity
Not Used.

HI03 C022 Health Care Code Information
Composit O Health Care Code Information
To send health care codes and their associated dates, amounts and quantities

*-01 1270 Code List Qualifier Code
ID 1 3 M Health Care Codes
Code identifying a specific industry code list
Codes:
BF Diagnosis

*-02 1271 Industry Code 70-05
AN 1 20 M Other Diagnosis Code-1
Code indicating a code from a specific industry code list
An ICD-9-CM Diagnosis Code identifying the diagnosis.

*-03 1250 Date Time Period Format Qualifier
Not Used.

*-04 1251 Date Time Period
Not Used.

*-05 0782 Monetary Amount
Not Used.

*-06 0380 Quantity
Not Used.

HI04 C022 Health Care Code Information
Composit O Health Care Code Information
To send health care codes and their associated dates, amounts and quantities

*-01 1270 Code List Qualifier Code
ID 1 3 M Health Care Codes
Code identifying a specific industry code list
Codes:
BF Diagnosis

*-02 1271 Industry Code 70-06
AN 1 20 M Other Diagnosis Code-2
Code indicating a code from a specific industry code list
An ICD-9-CM Diagnosis Code identifying the diagnosis.

*-03 1250 Date Time Period Format Qualifier
Not Used.

*-04 1251 Date Time Period
Not Used.

*-05 0782 Monetary Amount
Not Used.

*-06 0380 Quantity
Not Used.

HI05 C022 Health Care Code Information
Composit O Health Care Code Information
To send health care codes and their associated dates, amounts and quantities

*-01 1270 Code List Qualifier Code
ID 1 3 M Health Care Codes
Code identifying a specific industry code list
Codes:
BF Diagnosis

*-02 1271 Industry Code 70-07
AN 1 20 M Other Diagnosis Code-3
Code indicating a code from a specific industry code list
An ICD-9-CM Diagnosis Code identifying the diagnosis.

*-03 1250 Date Time Period Format Qualifier
Not Used.

*-04 1251 Date Time Period
Not Used.

*-05 0782 Monetary Amount
Not Used.

*-06 0380 Quantity
Not Used.

HI06 C022 Health Care Code Information
Composit O Health Care Code Information
To send health care codes and their associated dates, amounts and quantities

*-01 1270 Code List Qualifier Code
ID 1 3 M Health Care Codes
Code identifying a specific industry code list
Codes:
BF Diagnosis

*-02 1271 Industry Code 70-08
AN 1 20 M Other Diagnosis Code-4
Code indicating a code from a specific industry code list
An ICD-9-CM Diagnosis Code identifying the diagnosis.

*-03 1250 Date Time Period Format Qualifier
Not Used.

*-04 1251 Date Time Period
Not Used.

*-05 0782 Monetary Amount
Not Used.

*-06 0380 Quantity
Not Used.

HI07 C022 Health Care Code Information
Composit O Health Care Code Information
To send health care codes and their associated dates, amounts and quantities

*-01 1270 Code List Qualifier Code
ID 1 3 M Health Care Codes
Code identifying a specific industry code list
Codes:
BF Diagnosis

*-02 1271 Industry Code 70-09
AN 1 20 M Other Diagnosis Code-5
Code indicating a code from a specific industry code list
An ICD-9-CM Diagnosis Code identifying the diagnosis.

*-03 1250 Date Time Period Format Qualifier
Not Used.

*-04 1251 Date Time Period
Not Used.

*-05 0782 Monetary Amount
Not Used.

*-06 0380 Quantity
Not Used.

HI08 C022 Health Care Code Information
Composit O Health Care Code Information
To send health care codes and their associated dates, amounts and quantities

*-01 1270 Code List Qualifier Code
ID 1 3 M Health Care Codes
Code identifying a specific industry code list
Codes:
BF Diagnosis

*-02 1271 Industry Code 70-10
AN 1 20 M Other Diagnosis Code-6
Code indicating a code from a specific industry code list
An ICD-9-CM Diagnosis Code identifying the diagnosis.

*-03 1250 Date Time Period Format Qualifier
Not Used.

*-04 1251 Date Time Period
Not Used.

*-05 0782 Monetary Amount
Not Used.

*-06 0380 Quantity
Not Used.

HI09 C022 Health Care Code Information
Composit O Health Care Code Information
To send health care codes and their associated dates, amounts and quantities

*-01 1270 Code List Qualifier Code
ID 1 3 M Health Care Codes
Code identifying a specific industry code list
Codes:
BF Diagnosis

*-02 1271 Industry Code 70-11
AN 1 20 M Other Diagnosis Code-7
Code indicating a code from a specific industry code list
An ICD-9-CM Diagnosis Code identifying the diagnosis.

*-03 1250 Date Time Period Format Qualifier
Not Used.

*-04 1251 Date Time Period
Not Used.

*-05 0782 Monetary Amount
Not Used.

*-06 0380 Quantity
Not Used.

HI10 C022 Health Care Code Information
Composit O Health Care Code Information
To send health care codes and their associated dates, amounts and quantities

*-01 1270 Code List Qualifier Code
ID 1 3 M Health Care Codes
Code identifying a specific industry code list
Codes:
BF Diagnosis

*-02 1271 Industry Code 70-12
AN 1 20 M Other Diagnosis Code-8
Code indicating a code from a specific industry code list
An ICD-9-CM Diagnosis Code identifying the diagnosis.

*-03 1250 Date Time Period Format Qualifier
Not Used.

*-04 1251 Date Time Period
Not Used.

*-05 0782 Monetary Amount
Not Used.

*-06 0380 Quantity
Not Used.

HI11 C022 Health Care Code Information
Composit O Health Care Code Information
To send health care codes and their associated dates, amounts and quantities

*-01 1270 Code List Qualifier Code
ID 1 3 M Health Care Codes
Code identifying a specific industry code list
Codes:
BN United States Department of Health and Human Services, Office of Vital Statistics E-code

*-02 1271 Industry Code 70-26
AN 1 20 M E-Code
Code indicating a code from a specific industry code list
United States Department of Vital Statistics E-Code used to identify conditions related to the spell.

*-03 1250 Date Time Period Format Qualifier
Not Used.

*-04 1251 Date Time Period
Not Used.

*-05 0782 Monetary Amount
Not Used.

*-06 0380 Quantity
Not Used.

HI12 C022 Health Care Code Information
Not Used.

X12 Segment Name: **HI Health Care Information Codes**
Loop: 2300
Max. Use: 25
X12 Purpose: To supply information related to the delivery of health care (Procedure Codes)
Usage: **Optional**
Example: HI*BR:3420:D8:19941204*BR:3781:D8:19941207~

Element Attributes	Data Element Usage	**UB92 EMC VER.5.0 Mapping**
HI01 C022 Composit M	Health Care Code Information To send health care codes and their associated dates, amounts and quantities	
***-01** 1270 ID 1 3 M	Code List Qualifier Code Health Care Codes Code identifying a specific industry code list Codes: **BR** International Classification of Diseases Clinical Modification (ICD-9-CM) Principal Procedure	**70-27**
***-02** 1271 AN 1 20 M	Industry Code Principle Procedure Code Code indicating a code from a specific industry code list	**70-13**
***-03** 1250 ID 2 3 C	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format. Codes: **D8** Date Expressed in Format CCYYMMDD	
***-04** 1251 AN 1 35 C	Date Time Period Expression of a Date or Time	**70-14**
***-05** 0782	Monetary Amount **Not Used.**	
***-06** 0380	Quantity **Not Used.**	

HI02 C022 Composit O	Health Care Code Information Health Care Code Information To send health care codes and their associated dates, amounts and quantities	
***-01** 1270 ID 1 3 M	Code List Qualifier Code Health Care Codes Code identifying a specific industry code list Codes: **BQ** International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure	
***-02** 1271 AN 1 20 M	Industry Code Other Procedure Code Code indicating a code from a specific industry code list Other Procedure Code - 1	**70-15**
***-03** 1250 ID 2 3 C	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format. Codes: **D8** Date Expressed in Format CCYYMMDD	
***-04** 1251 AN 1 35 C	Date Time Period Procedure Date Expression of a date, a time, or range of dates, times or dates and times.	**70-16**
***-05** 0782	Monetary Amount **Not Used.**	
***-06** 0380	Quantity **Not Used.**	
HI03 C022 Composit O	Health Care Code Information Health Care Code Information To send health care codes and their associated dates, amounts and quantities	
***-01** 1270 ID 1 3 M	Code List Qualifier Code Health Care Codes Code identifying a specific industry code list Codes: **BQ** International Classification of	

	Diseases Clinical Modification (ICD-9-CM) Procedure		
***-02** 1271 AN 1 20 M	Industry Code Other Procedure Code - 2 Code indicating a code from a specific industry code list Other Procedure Code	**70-17**	
***-03** 1250 ID 2 3 C	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format. Codes: **D8** Date Expressed in Format CCYYMMDD		
***-04** 1251 AN 1 35 C	Date Time Period Procedure Date Expression of a date, a time, or range of dates, times or dates and times.	**70-18**	
***-05** 0782	Monetary Amount **Not Used.**		
***-06** 0380	Quantity **Not Used.**		
HI04 C022 Composit O	Health Care Code Information Health Care Code Information To send health care codes and their associated dates, amounts and quantities		
***-01** 1270 ID 1 3 M	Code List Qualifier Code Health Care Codes Code identifying a specific industry code list Codes: **BQ** International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure		
***-02** 1271 AN 1 20 M	Industry Code Other Procedure Code - 3 Code indicating a code from a specific industry code list Other Procedure Code		**70-19**
***-03** 1250	Date Time Period Format Qualifier		

ID 2 3 C
Code indicating the date format, time format, or date and time format.
Codes:
D8 Date Expressed in Format CCYYMMDD

***-04** 1251
AN 1 35 C
Date Time Period
Procedure Date **70-20**
Expression of a date, a time, or range of dates, times or dates and times.

***-05** 0782
Monetary Amount
Not Used.

***-06** 0380
Quantity
Not Used.

HI05 C022
Composit O
Health Care Code Information
Health Care Code Information
To send health care codes and their associated dates, amounts and quantities

***-01** 1270
ID 1 3 M
Code List Qualifier Code
Health Care Codes
Code identifying a specific industry code list
Codes:
BQ International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure

***-02** 1271
AN 1 20 M
Industry Code
Other Procedure Code - 4 **70-21**
Code indicating a code from a specific industry code list
Other ICD-9-CM Procedure Code

***-03** 1250
ID 2 3 C
Date Time Period Format Qualifier
Code indicating the date format, time format, or date and time format.
Codes:
D8 Date Expressed in Format CCYYMMDD

*-04 1251
AN 1 35 C
Date Time Period
Procedure Date **70-22**
Expression of a date, a time, or range of dates, times or dates and times.

***-05** 0782 Monetary Amount
Not Used.

***-06** 0380 Quantity
Not Used.

HI06 C022 Health Care Code Information
Composit O Health Care Code Information
To send health care codes and their associated dates, amounts and quantities

***-01** 1270 Code List Qualifier Code
ID 1 3 M Health Care Codes
Code identifying a specific industry code list
Codes:
BQ International Classification of Diseases Clinical Modification (ICD-9-CM) Procedure

***-02** 1271 Industry Code
AN 1 20 M Other Procedure Code - 5 **70-23**
Code indicating a code from a specific industry code list
Other ICD-9-CM Procedure Code

***-03** 1250 Date Time Period Format Qualifier
ID 2 3 C Code indicating the date format, time format, or date and time format.
Codes:
D8 Date Expressed in Format CCYYMMDD

***-04** 1251 Date Time Period
AN 1 35 C Procedure Date **70-24**
Expression of a date, a time, or range of dates, times or dates and times.

***-05** 0782 Monetary Amount
Not Used.

***-06** 0380 Quantity
Not Used.

HI07 C022 Health Care Code Information
Not Used.

HI08 C022 Health Care Code Information
Not Used.

HI09 C022 Health Care Code Information
Not Used.

HI10 C022 Health Care Code Information
Not Used.

HI11 C022 Health Care Code Information
Not Used.

HI12 C022 Health Care Code Information
Not Used.

X12 Segment Name: **HI Health Care Information Codes**
Loop: 2300
Max. Use: 25
X12 Purpose: To supply information related to the delivery of health care (Occurrence Codes)
Usage: **Optional**
Example: HI*BH:23:D8:19941204*BH:11:D8:19941207~

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
HI01 C022 Composit M	Health Care Code Information Health Care Code Information To send health care codes and their associated dates, amounts and quantities	
***-01** 1270 ID 1 3 M	Code List Qualifier Code Health Care Codes Code identifying a specific industry code list Codes: **BH** Occurrence	
***-02** 1271 AN 1 20 M	Industry Code Occurrence Code 1 Code indicating a code from a specific industry code list	**40-08**
***-03** 1250 ID 2 3 C	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format. Codes: **D8** Date Expressed in Format CCYYMMDD	
***-04** 1251 AN 1 35 C	Date Time Period Occurrence Date Expression of a date, a time, or range of dates, times or dates and times.	**40-09**
***-05** 0782	Monetary Amount **Not Used.**	
***-06** 0380	Quantity **Not Used.**	
HI02 C022 Composit O	Health Care Code Information Health Care Code Information To send health care codes and their	

associated dates, amounts and quantities

***-01** 1270 ID 1 3 M	Code List Qualifier Code Health Care Codes Code identifying a specific industry code list Codes: **BH** Occurrence	
***-02** 1271 AN 1 20 M	Industry Code Occurrence Code 2 Code indicating a code from a specific industry code list	**40-10**
***-03** 1250 ID 2 3 C	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format. Codes: **D8** Date Expressed in Format CCYYMMDD	
***-04** 1251 AN 1 35 C	Date Time Period Occurrence Date Expression of a date, a time, or range of dates, times or dates and times.	**40-11**
***-05** 0782	Monetary Amount **Not Used.**	
***-06** 0380	Quantity **Not Used.**	
HI03 C022 Composit O	Health Care Code Information Health Care Code Information To send health care codes and their associated dates, amounts and quantities	
***-01** 1270 ID 1 3 M	Code List Qualifier Code Health Care Codes Code identifying a specific industry code list Codes: **BH** Occurrence	
***-02** 1271 AN 1 20 M	Industry Code Occurrence Code 3 Code indicating a code from a specific industry code list	**40-12**

***-03** 1250 ID 2 3 C	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format. Codes: **D8** Date Expressed in Format CCYYMMDD	
***-04** 1251 AN 1 35 C	Date Time Period Occurrence Date Expression of a date, a time, or range of dates, times or dates and times.	**40-13**
***-05** 0782	Monetary Amount **Not Used.**	
***-06** 0380	Quantity **Not Used.**	
HI04 C022 Composit O	Health Care Code Information Health Care Code Information To send health care codes and their associated dates, amounts and quantities	
***-01** 1270 ID 1 3 M	Code List Qualifier Code Health Care Codes Code identifying a specific industry code list Codes: **BH** Occurrence	
***-02** 1271 AN 1 20 M	Industry Code Occurrence Code 4 Code indicating a code from a specific industry code list	**40-14**
***-03** 1250 ID 2 3 C	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format. Codes: **D8** Date Expressed in Format CCYYMMDD	
***-04** 1251 AN 1 35 C	Date Time Period Occurrence Date Expression of a date, a time, or range of dates, times or dates and times.	**40-15**

***-05** 0782	Monetary Amount **Not Used.**	
***-06** 0380	Quantity **Not Used.**	
HI05 C022 Composit O	Health Care Code Information Health Care Code Information To send health care codes and their associated dates, amounts and quantities	
***-01** 1270 ID 1 3 M	Code List Qualifier Code Health Care Codes Code identifying a specific industry code list Codes: **BH** Occurrence	
***-02** 1271 AN 1 20 M	Industry Code Occurrence Code 5 Code indicating a code from a specific industry code list	**40-16**
***-03** 1250 ID 2 3 C	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format. Codes: **D8** Date Expressed in Format CCYYMMDD	
***-04** 1251 AN 1 35 C	Date Time Period Occurrence Date Expression of a date, a time, or range of dates, times or dates and times.	**40-17**
***-05** 0782	Monetary Amount **Not Used.**	
***-06** 0380	Quantity **Not Used.**	
HI06 C022 Composit O	Health Care Code Information Health Care Code Information To send health care codes and their associated dates, amounts and quantities	
***-01** 1270	Code List Qualifier Code	

ID 1 3 M	Health Care Codes Code identifying a specific industry code list Codes: **BH** Occurrence	
***-02** 1271 AN 1 20 M	Industry Code Occurrence Code 6 Code indicating a code from a specific industry code list	**40-18**
***-03** 1250 ID 2 3 C	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format. Codes: **D8** Date Expressed in Format CCYYMMDD	
***-04** 1251 AN 1 35 C	Date Time Period Occurrence Date Expression of a date, a time, or range of dates, times or dates and times.	**40-19**
***-05** 0782	Monetary Amount **Not Used.**	
***-06** 0380	Quantity **Not Used.**	
HI07 C022 Composit O	Health Care Code Information Health Care Code Information To send health care codes and their associated dates, amounts and quantities	
***-01** 1270 ID 1 3 M	Code List Qualifier Code Health Care Codes Code identifying a specific industry code list Codes: **BH** Occurrence	
***-02** 1271 AN 1 20 M	Industry Code Occurrence Code 7 Code indicating a code from a specific industry code list	**40-20**
***-03** 1250 ID 2 3 C	Date Time Period Format Qualifier Code indicating the date format, time	

	format, or date and time format. Codes: **D8** Date Expressed in Format CCYYMMDD	
***-04** 1251 AN 1 35 C	Date Time Period Occurrence Date Expression of a date, a time, or range of dates, times or dates and times.	**40-21**
***-05** 0782	Monetary Amount **Not Used.**	
***-06** 0380	Quantity **Not Used.**	
HI08 C022	Health Care Code Information **Not Used.**	
HI09 C022	Health Care Code Information **Not Used.**	
HI10 C022	Health Care Code Information **Not Used.**	
HI11 C022	Health Care Code Information **Not Used.**	
HI12 C022	Health Care Code Information **Not Used.**	

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X12 Segment Name: **HI Health Care Information Codes**
Loop: 2300
Max. Use: 25
X12 Purpose: To supply information related to the delivery of health care (Occurrence Span Codes)
Usage: **Optional**
Example: HI*BI:01:RD8:19941204-19941207~

Element Mapping Attributes	Data Element Usage	**UB92 EMC VER.5.0 Mapping**
HI01 C022 Composit M	Health Care Code Information Health Care Code Information To send health care codes and their associated dates, amounts and quantities	
***-01** 1270 ID 1 3 M	Code List Qualifier Code Health Care Codes Code identifying a specific industry code list Codes: **BI** Occurrence Span	
***-02** 1271 AN 1 20 M	Industry Code Occurrence Span Code 1 Code indicating a code from a specific industry code list	**40-22**
***-03** 1250 ID 2 3 C	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format. Codes: **RD8** Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD	
***-04** 1251 AN 1 35 C	Date Time Period Occurrence Span Date Expression of a date, a time, or range of dates, times or dates and times.	**40-23, 40-24**
***-05** 0782	Monetary Amount **Not Used.**	
*-06 0380	Quantity **Not Used.**	
HI02 C022 Composit O	Health Care Code Information Health Care Code Information	

To send health care codes and their associated dates, amounts and quantities

***-01** 1270
ID 1 3 M
Code List Qualifier Code
Health Care Codes
Code identifying a specific industry code list
Codes:
BI Occurrence Span

***-02** 1271
AN 1 20 M
Industry Code
Occurrence Span Code 2 **40-25**
Code indicating a code from a specific industry code list

***-03** 1250
ID 2 3 C
Date Time Period Format Qualifier
Code indicating the date format, time format, or date and time format.
Codes:
RD8 Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD

***-04** 1251
AN 1 35 C
Date Time Period
Occurrence Span Date **40-26, 40-27**
Expression of a date, a time, or range of dates, times or dates and times.

***-05** 0782
Monetary Amount
Not Used.

***-06** 0380
Quantity
Not Used.

HI03 C022
Health Care Code Information
Not Used.

HI04 C022
Health Care Code Information
Not Used.

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HI05	C022	Health Care Code Information Not Used.
HI06	C022	Health Care Code Information Not Used.
HI07	C022	Health Care Code Information Not Used.
HI08	C022	Health Care Code Information Not Used.
HI09	C022	Health Care Code Information Not Used.
HI10	C022	Health Care Code Information Not Used.
HI11	C022	Health Care Code Information Not Used.
HI12	C022	Health Care Code Information Not Used.

X12 Segment Name: HI Health Care Information Codes
Loop: 2300
Max. Use: 25
X12 Purpose: To supply information related to the delivery of health care
Usage: Optional
Example: HI*BG:01~

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
HI01 C022 Composit M	Health Care Code Information Health Care Code Information To send health care codes and their associated dates, amounts and quantities	
*-01 1270 ID 1 3 M	Code List Qualifier Code Health Care Codes Code identifying a specific industry code list Codes: BG Condition	
*-02 1271 AN 1 20 M	Industry Code Condition Code 1 Code indicating a code from a specific industry code list Codes used to identify conditions that may affect payor processing.	41-04
*-03 1250	Date Time Period Format Qualifier Not Used.	
*-04 1251	Date Time Period Not Used.	
*-05 0782	Monetary Amount Not Used.	
*-06 0380	Quantity Not Used.	
HI02 C022 Composit O	Health Care Code Information Health Care Code Information To send health care codes and their associated dates, amounts and quantities	

*-01 1270 Code List Qualifier Code
ID 1 3 M Health Care Codes
Code identifying a specific industry code list
Codes:
BG Condition

*-02 1271 Industry Code 41-05
AN 1 20 M Condition Code 2
Code indicating a code from a specific industry code list
Codes used to identify conditions that may affect payor processing.

*-03 1250 Date Time Period Format Qualifier
Not Used.

*-04 1251 Date Time Period
Not Used.

*-05 0782 Monetary Amount
Not Used.

*-06 0380 Quantity
Not Used.

HI03 C022 Health Care Code Information
Composit O Health Care Code Information
To send health care codes and their associated dates, amounts and quantities

*-01 1270 Code List Qualifier Code
ID 1 3 M Health Care Codes
Code identifying a specific industry code list
Codes:
BG Condition

*-02 1271 Industry Code 41-06
AN 1 20 M Condition Code 3
Code indicating a code from a specific industry code list
Codes used to identify conditions that may affect payor processing.

*-03 1250 Date Time Period Format Qualifier
Not Used.

*-04 1251 Date Time Period
Not Used.

*-05 0782 Monetary Amount
Not Used.

*-06 0380 Quantity
Not Used.

HI04 C022 Health Care Code Information
Composit O Health Care Code Information
To send health care codes and their associated dates, amounts and quantities

*-01 1270 Code List Qualifier Code
ID 1 3 M Health Care Codes
Code identifying a specific industry code list
Codes:
BG Condition

*-02 1271 Industry Code 41-07
AN 1 20 M Condition Code 4
Code indicating a code from a specific industry code list
Codes used to identify conditions that may affect payor processing.

*-03 1250 Date Time Period Format Qualifier
Not Used.

*-04 1251 Date Time Period
Not Used.

*-05 0782 Monetary Amount
Not Used.

*-06 0380 Quantity
Not Used.

HI05 C022 Health Care Code Information
Composit O Health Care Code Information
To send health care codes and their associated dates, amounts and quantities

*-01 1270 Code List Qualifier Code
ID 1 3 M Health Care Codes
Code identifying a specific industry code list
Codes:
BG Condition

*-02 1271 Industry Code 41-08
AN 1 20 M Condition Code 5
Code indicating a code from a specific industry code list
Codes used to identify conditions that may affect payor processing.

*-03 1250 Date Time Period Format Qualifier
Not Used.

*-04 1251 Date Time Period
Not Used.

*-05 0782 Monetary Amount
Not Used.

*-06 0380 Quantity
Not Used.

HI06 C022 Health Care Code Information
Composit O Health Care Code Information
To send health care codes and their associated dates, amounts and quantities

*-01 1270 Code List Qualifier Code
ID 1 3 M Health Care Codes
Code identifying a specific industry code list
Codes:
BG Condition

*-02 1271 Industry Code 41-09
AN 1 20 M Condition Code 6
Code indicating a code from a specific industry code list
Codes used to identify conditions that may affect payor processing.

*-03 1250 Date Time Period Format Qualifier
Not Used.

*-04 1251 Date Time Period
Not Used.

*-05 0782 Monetary Amount
Not Used.

*-06 0380 Quantity
Not Used.

HI07 C022 Health Care Code Information
Composit O Health Care Code Information
To send health care codes and their associated dates, amounts and quantities

*-01 1270 Code List Qualifier Code
ID 1 3 M Health Care Codes
Code identifying a specific industry code list
Codes:
BG Condition

*-02 1271 Industry Code 41-10
AN 1 20 M Condition Code 7
Code indicating a code from a specific industry code list
Codes used to identify conditions that may affect payor processing.

*-03 1250 Date Time Period Format Qualifier
Not Used.

*-04 1251 Date Time Period
Not Used.

*-05 0782 Monetary Amount
Not Used.

*-06 0380 Quantity
Not Used.

HI08 C022 Health Care Code Information
Composit O Health Care Code Information
To send health care codes and their associated dates, amounts and quantities

*-01 1270 Code List Qualifier Code
ID 1 3 M Health Care Codes
Code identifying a specific industry code list
Codes:
BG Condition

*-02 1271 Industry Code 41-11
AN 1 20 M Condition Code 8
Code indicating a code from a specific industry code list
Codes used to identify conditions that may affect payor processing.

*-03 1250 Date Time Period Format Qualifier
Not Used.

*-04 1251 Date Time Period
Not Used.

*-05 0782 Monetary Amount
Not Used.

*-06 0380 Quantity
Not Used.

HI09 C022 Health Care Code Information
Composit O Health Care Code Information
To send health care codes and their associated dates, amounts and quantities

*-01 1270 Code List Qualifier Code
ID 1 3 M Health Care Codes
Code identifying a specific industry code list
Codes:
BG Condition

*-02 1271 Industry Code 41-12
AN 1 20 M Condition Code 9
Code indicating a code from a specific industry code list
Codes used to identify conditions that may affect payor processing.

*-03 1250 Date Time Period Format Qualifier
Not Used.

*-04	1251	Date Time Period Not Used.	
*-05	0782	Monetary Amount Not Used.	
*-06	0380	Quantity Not Used.	
HI10	C022	Health Care Code Information	
Composit	O	Health Care Code Information To send health care codes and their associated dates, amounts and quantities	
*-01	1270	Code List Qualifier Code	
ID 1 3	M	Health Care Codes Code identifying a specific industry code list Codes: BG Condition	
*-02	1271	Industry Code	41-13
AN 1 20	M	Condition Code 10 Code indicating a code from a specific industry code list Codes used to identify conditions that may affect payor processing.	
*-03	1250	Date Time Period Format Qualifier Not Used.	
*-04	1251	Date Time Period Not Used.	
*-05	0782	Monetary Amount Not Used.	
*-06	0380	Quantity Not Used.	
HI11	C022	Health Care Code Information Not Used.	
HI12	C022	Health Care Code Information Not Used.	

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X12 Segment Name: HI Health Care Information Codes
Loop: 2300
Max. Use: 25
X12 Purpose: To supply information related to the delivery of health care
Usage: Optional
Example: HI*BE:01:::200.5*BE:04:::10~

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
HI01 C022 Composit M	Health Care Code Information Health Care Code Information To send health care codes and their associated dates, amounts and quantities	
*-01 1270 ID 1 3 M	Code List Qualifier Code Health Care Codes Code identifying a specific industry code list Codes: BE Value	
*-02 1271 AN 1 20 M	Industry Code Value Code 1 Code indicating a code from a specific industry code list	41-16
*-03 1250	Date Time Period Format Qualifier Not Used.	
*-04 1251	Date Time Period Not Used.	
*-05 0782 R 1 15 O	Monetary Amount Value Amount Monetary amount.	41-17
*-06 0380	Quantity Not Used.	
HI02 C022 Composit O	Health Care Code Information Health Care Code Information To send health care codes and their associated dates, amounts and quantities	

*-01 1270 Code List Qualifier Code

ID 1 3 M	Health Care Codes Code identifying a specific industry code list Codes: BE Value	
*-02 1271 AN 1 20 M	Industry Code Value Code 2 Code indicating a code from a specific industry code list	41-18
*-03 1250	Date Time Period Format Qualifier Not Used.	
*-04 1251	Date Time Period Not Used.	
*-05 0782 R 1 15 O	Monetary Amount Value Amount Monetary amount.	41-19
*-06 0380	Quantity Not Used.	
HI03 C022 Composit O	Health Care Code Information Health Care Code Information To send health care codes and their associated dates, amounts and quantities	
*-01 1270 ID 1 3 M	Code List Qualifier Code Health Care Codes Code identifying a specific industry code list Codes: BE Value	
*-02 1271 AN 1 20 M	Industry Code Value Code 3 Code indicating a code from a specific industry code list	41-20
*-03 1250	Date Time Period Format Qualifier Not Used.	
*-04 1251	Date Time Period Not Used.	

*-05 0782 R 1 15 O	Monetary Amount Value Amount Monetary amount.	41-21
*-06 0380	Quantity Not Used.	
HI04 C022 Composit O	Health Care Code Information Health Care Code Information To send health care codes and their associated dates, amounts and quantities	
*-01 1270 ID 1 3 M	Code List Qualifier Code Health Care Codes Code identifying a specific industry code list Codes: BE Value	
*-02 1271 AN 1 20 M	Industry Code Value Code 4 Code indicating a code from a specific industry code list	41-22
*-03 1250	Date Time Period Format Qualifier Not Used.	
*-04 1251	Date Time Period Not Used.	
*-05 0782 R 1 15 O	Monetary Amount Value Amount Monetary amount.	41-23
*-06 0380	Quantity Not Used.	
HI05 C022 Composit O	Health Care Code Information Health Care Code Information To send health care codes and their associated dates, amounts and quantities	
*-01 1270 ID 1 3 M	Code List Qualifier Code Health Care Codes Code identifying a specific industry code list	

	Codes: BE Value	
*-02 1271 AN 1 20 M	Industry Code Value Code 5 Code indicating a code from a specific industry code list	41-24
*-03 1250	Date Time Period Format Qualifier Not Used.	
*-04 1251	Date Time Period Not Used.	
*-05 0782 R 1 15 O	Monetary Amount Value Amount Monetary amount.	41-25
*-06 0380	Quantity Not Used.	
HI06 C022 Composit O	Health Care Code Information Health Care Code Information To send health care codes and their associated dates, amounts and quantities	
*-01 1270 ID 1 3 M	Code List Qualifier Code Health Care Codes Code identifying a specific industry code list Codes: BE Value	
*-02 1271 AN 1 20 M	Industry Code Value Code 6 Code indicating a code from a specific industry code list	41-26
*-03 1250	Date Time Period Format Qualifier Not Used.	
*-04 1251	Date Time Period Not Used.	
*-05 0782	Monetary Amount	41-27

R 1 15 O	Value Amount Monetary amount.	
*-06 0380	Quantity Not Used.	
HI07 C022 Composit O	Health Care Code Information Health Care Code Information To send health care codes and their associated dates, amounts and quantities	
*-01 1270 ID 1 3 M	Code List Qualifier Code Health Care Codes Code identifying a specific industry code list Codes: BE Value	
*-02 1271 AN 1 20 M	Industry Code Value Code 7 Code indicating a code from a specific industry code list	41-28
*-03 1250	Date Time Period Format Qualifier Not Used.	
*-04 1251	Date Time Period Not Used.	
*-05 0782 R 1 15 O	Monetary Amount Value Amount Monetary amount.	41-29
*-06 0380	Quantity Not Used.	
HI08 C022 Composit O	Health Care Code Information Health Care Code Information To send health care codes and their associated dates, amounts and quantities	
*-01 1270 ID 1 3 M	Code List Qualifier Code Health Care Codes Code identifying a specific industry code list Codes:	

BE Value

*-02 1271 Industry Code 41-30
AN 1 20 M Value Code 8
Code indicating a code from a specific industry code list

*-03 1250 Date Time Period Format Qualifier
Not Used.

*-04 1251 Date Time Period
Not Used.

*-05 0782 Monetary Amount 41-31
R 1 15 O Value Amount
Monetary amount.

*-06 0380 Quantity
Not Used.

HI09 C022 Health Care Code Information
Composit O Health Care Code Information
To send health care codes and their associated dates, amounts and quantities

*-01 1270 Code List Qualifier Code
ID 1 3 M Health Care Codes
Code identifying a specific industry code list
Codes:
BE Value

*-02 1271 Industry Code 41-32
AN 1 20 M Value Code 9
Code indicating a code from a specific industry code list

*-03 1250 Date Time Period Format Qualifier
Not Used.

*-04 1251 Date Time Period
Not Used.

*-05 0782 Monetary Amount 41-33
R 1 15 O Value Amount

Monetary amount.

*-06 0380 Quantity
Not Used.

HI10 C022 Health Care Code Information
Composit O Health Care Code Information
To send health care codes and their associated dates, amounts and quantities

*-01 1270 Code List Qualifier Code
ID 1 3 M Health Care Codes
Code identifying a specific industry code list
Codes:
BE Value

*-02 1271 Industry Code 41-34
AN 1 20 M Value Code 10
Code indicating a code from a specific industry code list

*-03 1250 Date Time Period Format Qualifier
Not Used.

*-04 1251 Date Time Period
Not Used.

*-05 0782 Monetary Amount 41-35
R 1 15 O Value Amount
Monetary amount.

*-06 0380 Quantity
Not Used.

HI11 C022 Health Care Code Information
Composit O Health Care Code Information
To send health care codes and their associated dates, amounts and quantities

*-01 1270 Code List Qualifier Code
ID 1 3 M Health Care Codes
Code identifying a specific industry code list
Codes:
BE Value

*-02 1271	Industry Code	41-36
AN 1 20 M	Value Code 11	
	Code indicating a code from a specific industry code list	
*-03 1250	Date Time Period Format Qualifier	
	Not Used.	
*-04 1251	Date Time Period	
	Not Used.	
*-05 0782	Monetary Amount	41-37
R 1 15 O	Value Amount	
	Monetary amount.	
*-06 0380	Quantity	
	Not Used.	
HI12 C022	Health Care Code Information	
Composit O	Health Care Code Information	
	To send health care codes and their associated dates, amounts and quantities	
*-01 1270	Code List Qualifier Code	
ID 1 3 M	Health Care Codes	
	Code identifying a specific industry code list	
	Codes:	
	BE Value	
*-02 1271	Industry Code	41-38
AN 1 20 M	Value Code 12	
	Code indicating a code from a specific industry code list	
*-03 1250	Date Time Period Format Qualifier	
	Not Used.	
*-04 1251	Date Time Period	
	Not Used.	
*-05 0782	Monetary Amount	41-39
R 1 15 O	Value Amount	
	Monetary amount.	

*-06 0380 Quantity
Not Used.

X12 Segment Name: HI Health Care Information Codes
Loop: 2300
Max. Use: 25
X12 Purpose: To supply information related to the delivery of health care
Usage: Optional
Example: HI*TC:01~
Comments: Use only if generating the RT 72 UB-92 home health attachment.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
HI01 C022	Health Care Code Information	
Composit M	Health Care Code Information To send health care codes and their associated dates, amounts and quantities	
*-01 1270	Code List Qualifier Code	
ID 1 3 M	Health Care Codes Code identifying a specific industry code list Codes: TC Treatment Codes	
*-02 1271	Industry Code	72-18, 72-30, 72-42
AN 1 20 M	Treatment Code - 1 or 13 or 25 Code indicating a code from a specific industry code list Use only if generating RT 72 home health attachment. Codes describing the treatment ordered by the physician. Show in ascending order. Valid codes are: A01-A30= Skilled nursing, B01-B15= Physical Therapy, C01-C09= Speech Therapy, D01-D11= Occupational Therapy, E01-E06= Medical School Services, F01-F15= Home Health Aide.	
*-03 1250	Date Time Period Format Qualifier Not Used.	
*-04 1251	Date Time Period Not Used.	
*-05 0782	Monetary Amount Not Used.	
*-06 0380	Quantity	

Not Used.

HI02 C022 Health Care Code Information
Composit O Health Care Code Information
To send health care codes and their associated dates, amounts and quantities

*-01 1270 Code List Qualifier Code
ID 1 3 M Health Care Codes
Code identifying a specific industry code list
Codes:
TC Treatment Codes

*-02 1271 Industry Code 72-19, 72-31
AN 1 20 M Treatment Code - 2 or 14
Code indicating a code from a specific industry code list
See HI01-02 for code list.
Use only if generating RT 72 home health attachment.

*-03 1250 Date Time Period Format Qualifier
Not Used.

*-04 1251 Date Time Period
Not Used.

*-05 0782 Monetary Amount
Not Used.

*-06 0380 Quantity
Not Used.

HI03 C022 Health Care Code Information
Composit O Health Care Code Information
To send health care codes and their associated dates, amounts and quantities

*-01 1270 Code List Qualifier Code
ID 1 3 M Health Care Codes
Code identifying a specific industry code list
Codes:
TC Treatment Codes

*-02 1271 Industry Code 72-20, 72-32

AN 1 20 M	Treatment Code - 3 or 15 Code indicating a code from a specific industry code list See HI01-02 for code list. Use only if generating RT 72 home health attachment.	
*-03 1250	Date Time Period Format Qualifier Not Used.	
*-04 1251	Date Time Period Not Used.	
*-05 0782	Monetary Amount Not Used.	
*-06 0380	Quantity Not Used.	
HI04 C022 Composit O	Health Care Code Information Health Care Code Information To send health care codes and their associated dates, amounts and quantities	
*-01 1270 ID 1 3 M	Code List Qualifier Code Health Care Codes Code identifying a specific industry code list Codes: TC Treatment Codes	
*-02 1271 AN 1 20 M	Industry Code Treatment Code - 4 or 16 Code indicating a code from a specific industry code list See HI01-02 for code list. Use only if generating RT 72 home health attachment.	72-21, 72-33
*-03 1250	Date Time Period Format Qualifier Not Used.	
*-04 1251	Date Time Period Not Used.	
*-05 0782	Monetary Amount Not Used.	

*-06 0380	Quantity Not Used.	
HI05 C022 Composit O	Health Care Code Information Health Care Code Information To send health care codes and their associated dates, amounts and quantities	
*-01 1270 ID 1 3 M	Code List Qualifier Code Health Care Codes Code identifying a specific industry code list Codes: TC Treatment Codes	
*-02 1271 AN 1 20 M	Industry Code Treatment Code - 5 or 17 Code indicating a code from a specific industry code list See HI01-02 for code list. Use only if generating RT 72 home health attachment.	72-22, 72-34
*-03 1250	Date Time Period Format Qualifier Not Used.	
*-04 1251	Date Time Period Not Used.	
*-05 0782	Monetary Amount Not Used.	
*-06 0380	Quantity Not Used.	
HI06 C022 Composit O	Health Care Code Information Health Care Code Information To send health care codes and their associated dates, amounts and quantities	
*-01 1270 ID 1 3 M	Code List Qualifier Code Health Care Codes Code identifying a specific industry code list Codes: TC Treatment Codes	

*-02 1271 AN 1 20 M	Industry Code Treatment Code - 6 or 18 Code indicating a code from a specific industry code list See HI01-02 for code list. Use only if generating RT 72 home health attachment.	72-23, 72-35
*-03 1250	Date Time Period Format Qualifier Not Used.	
*-04 1251	Date Time Period Not Used.	
*-05 0782	Monetary Amount Not Used.	
*-06 0380	Quantity Not Used.	
HI07 C022 Composit O	Health Care Code Information Health Care Code Information To send health care codes and their associated dates, amounts and quantities	
*-01 1270 ID 1 3 M	Code List Qualifier Code Health Care Codes Code identifying a specific industry code list Codes: TC Treatment Codes	
*-02 1271 AN 1 20 M	Industry Code Treatment Code - 7 or 19 Code indicating a code from a specific industry code list See HI01-02 for code list. Use only if generating RT 72 home health attachment.	72-24, 72-36
*-03 1250	Date Time Period Format Qualifier Not Used.	
*-04 1251	Date Time Period Not Used.	
*-05 0782	Monetary Amount Not Used.	

*-06 0380	Quantity Not Used.	
HI08 C022 Composit O	Health Care Code Information Health Care Code Information To send health care codes and their associated dates, amounts and quantities	
*-01 1270 ID 1 3 M	Code List Qualifier Code Health Care Codes Code identifying a specific industry code list Codes: TC Treatment Codes	
*-02 1271 AN 1 20 M	Industry Code Treatment Code - 8 or 20 Code indicating a code from a specific industry code list See HI01-02 for code list. Use only if generating RT 72 home health attachment.	72-25, 72-37
*-03 1250	Date Time Period Format Qualifier Not Used.	
*-04 1251	Date Time Period Not Used.	
*-05 0782	Monetary Amount Not Used.	
*-06 0380	Quantity Not Used.	
HI09 C022 Composit O	Health Care Code Information Health Care Code Information To send health care codes and their associated dates, amounts and quantities	
*-01 1270 ID 1 3 M	Code List Qualifier Code Health Care Codes Code identifying a specific industry code list Codes: TC Treatment Codes	

*-02 1271 AN 1 20 M	Industry Code Treatment Code - 9 or 21 Code indicating a code from a specific See HI01-02 for code list. industry code list Use only if generating RT 72 home health attachment.	72-26, 72-38
*-03 1250	Date Time Period Format Qualifier Not Used.	
*-04 1251	Date Time Period Not Used.	
*-05 0782	Monetary Amount Not Used.	
*-06 0380	Quantity Not Used.	
HI10 C022 Composit O	Health Care Code Information Health Care Code Information To send health care codes and their associated dates, amounts and quantities	
*-01 1270 ID 1 3 M	Code List Qualifier Code Health Care Codes Code identifying a specific industry code list Codes: TC Treatment Codes	
*-02 1271 AN 1 20 M	Industry Code Treatment Code - 10 or 22 Code indicating a code from a specific See HI01-02 for code list. industry code list Use only if generating RT 72 home health attachment.	72-27, 72-39
*-03 1250	Date Time Period Format Qualifier Not Used.	
*-04 1251	Date Time Period Not Used.	
*-05 0782	Monetary Amount Not Used.	

*-06 0380	Quantity Not Used.	
HI11 C022 Composit O	Health Care Code Information Health Care Code Information To send health care codes and their associated dates, amounts and quantities	
*-01 1270 ID 1 3 M	Code List Qualifier Code Health Care Codes Code identifying a specific industry code list Codes: TC Treatment Codes	
*-02 1271 AN 1 20 M	Industry Code Treatment Code - 11 or 23 Code indicating a code from a specific industry code list See HI01-02 for code list. Use only if generating RT 72 home health attachment.	72-28, 72-40
*-03 1250	Date Time Period Format Qualifier Not Used.	
*-04 1251	Date Time Period Not Used.	
*-05 0782	Monetary Amount Not Used.	
*-06 0380	Quantity Not Used.	
HI12 C022 Composit O	Health Care Code Information Health Care Code Information To send health care codes and their associated dates, amounts and quantities	
*-01 1270 ID 1 3 M	Code List Qualifier Code Health Care Codes Code identifying a specific industry code list Codes: TC Treatment Codes	

*-02 1271	Industry Code	72-29
AN 1 20 M	Treatment Code - 12 Code indicating a code from a specific See HI01-02 for code list. industry code list Use only if generating RT 72 home health attachment.	
*-03 1250	Date Time Period Format Qualifier Not Used.	
*-04 1251	Date Time Period Not Used.	
*-05 0782	Monetary Amount Not Used.	
*-06 0380	Quantity Not Used.	

X12 Segment Name: QTY Quantity
Name: Covered Days Actual
Loop: 2300
Max. Use: 1
X12 Purpose: To specify quantity information.
Usage: Conditional
Example: QTY*CA*5*DA~

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
QTY01 0673 ID 2 2 M	Quantity Qualifier Code specifying the type of quantity. Codes: CA Covered - Actual Days covered on this service	
QTY02 0380 R 1 15 M	Quantity Covered Days Actual Numeric value of quantity.	30-20
QTY03 0355 ID 2 2 O	Unit or Basis for Measurement Code Days Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken Codes: DA Days	

X12 Segment Name: QTY Quantity
Name: Non-Covered Days Actual
Loop: 2300
Max. Use: 1
X12 Purpose: To specify quantity information.
Usage: Optional
Example: QTY*NA*2*DA~

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
QTY01 0673 ID 2 2 M	Quantity Qualifier Code specifying the type of quantity. Codes: NA Number of Non-covered Days	
QTY02 0380 R 1 15 M	Quantity Non-Covered Days Actual Numeric value of quantity.	30-21
QTY03 0355 ID 2 2 O	Unit or Basis for Measurement Code Days Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken Codes: DA Days	

X12 Segment Name: QTY Quantity
Name: Co-Insurance Days Actual
Loop: 2300
Max. Use: 1
X12 Purpose: To specify quantity information.
Usage: Optional
Example: QTY*CD*2*DA~

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
QTY01 0673 ID 2 2 M	Quantity Qualifier Code specifying the type of quantity. Codes: CD Co-insured - Actual	
QTY02 0380 R 1 15 M	Quantity Co-Insurance Days Actual Numeric value of quantity.	30-22
QTY03 0355 ID 2 2 O	Unit or Basis for Measurement Code Days Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken Codes: DA Days	

X12 Segment Name: QTY Quantity
Name: Lifetime Reserve Days Actual
Loop: 2300
Max. Use: 1
X12 Purpose: To specify quantity information.
Usage: Optional
Example: QTY*LA*100*DA~

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
QTY01 0673 ID 2 2 M	Quantity Qualifier Code specifying the type of quantity. Codes: LA Life-time Reserve - Actual Medicare hospital insurance includes extra hospital days to be used if the patient has a long illness and is required to stay in the hospital over a specified number of days; this is the actual number of days in reserve	
QTY02 0380 R 1 15 M	Quantity Lifetime Reserve Days Actual Numeric value of quantity.	30-23
QTY03 0355 ID 2 2 O	Unit or Basis for Measurement Code Days Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken Codes: DA Days	

X12 Segment Name: CR7 Home Health Treatment Plan Certification
Loop: 2305
Max. Use: 1
X12 Purpose: To supply information related to the home health care plan of treatment and services
Usage: Optional
Example: CR7*SN*12*15~
Comments: This segment should only be generated when generating the UB-92 RT 72 home health attachment.

Semantic Note: CR702 is the total visits on this bill rendered prior to the recertification "to" date.
Semantic Note: CR703 is the total visits projected during this certification period.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
CR701 0921 ID 2 2 M	Discipline Type Code Discipline Code indicating disciplines ordered by a physician Codes: AI Home Health Aide MS Medical Social Worker OT Occupational Therapy PT Physical Therapy SN Skilled Nursing ST Speech Therapy	72-4
CR702 1470 N0 1 9 M	Number Visits (this bill) Related to Prior Certification A generic number Total visits on this bill rendered prior to recertification "to" date.	72-5
CR703 1470 N0 1 9 M	Number Total Visits Projected During this Certification Period A generic number Total covered visits to be rendered by each discipline during the period covered by the POT. Include PRN visits.	72-43

X12 Segment Name: HSD Health Care Services Delivery
Loop: 2305
Max. Use: 12
X12 Purpose: To specify the delivery pattern of health care services
Usage: Optional
Example: HSD*VS*2*WK**35*090~

Syntax Note: P0102 - If either HSD01 or HSD02 is present, then the other must be present.
Syntax Note: C0605 - If HSD06 is present, then HSD05 must be present.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
HSD01 0673 ID 2 2 C	Quantity Qualifier Code specifying the type of quantity. Codes: VS Visits	
HSD02 0380 R 1 15 C	Quantity Frequency Number - 1 Numeric value of quantity.	72-6 (position 1), 72-7 thru 72-17 (position 1)
HSD03 0355 ID 2 2 O	Unit or Basis for Measurement Code Frequency Period - 1 Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken Q = every n days where n = number in positions 4-6. Codes: DA Days WK Week MO Months Q1 Quarter (Time)	72-6 (positions 2-3), 72-7 thru 72-17 (position 2-3)
HSD04 1167	Sample Selection Modules Not Used.	
HSD05 0615 ID 1 2 C	Time Period Qualifier Code defining periods. Codes: 35 Week	
HSD06 0616 N0 1 3 O	Number of Periods Duration - 1 Total number of periods. Duration of days 001-999	72-6 (positions 4-6), 72-7 thru 72-17 (position 4-6)

HSD07 0678 Ship/Delivery or Calendar Pattern Code
Not Used.

HSD08 0679 Ship/Delivery Pattern Time Code
Not Used.

X12 Segment Name: LS Loop Header
Loop: 2300
Max. Use: 1
X12 Purpose: To indicate that the next segment begins a loop
Usage: Optional
Example: LS*2310~
Comments: This segment MUST be used once, and only once, if NM1 at position 250 is used, regardless of the number of repetitions of loop 2310.

Semantic Note: One loop may be nested contained within another loop, provided the inner nested loop terminates before the outer loop. When specified by the standard setting body as "mandatory", this segment in combination with "LE", must be used. It is not to be used if not specifically set forth for use. The loop identifier in the loop header and trailer must be identical. The value for the identifier is the loop ID of the required loop segment. The loop ID number is given on the transaction set diagram in the appropriate ASC X12 version/release.

X12 Comment: See Figures Appendix for an explanation of the use of the LS and LE segments.

Element Attributes	Data Element Usage
LS01 0447 AN 1 4 M	Loop Identifier Code The loop ID number given on the transaction set diagram is the value for this data element in segments LS and LE Use 2310

X12 Segment Name: NM1 Individual or Organizational Name
Name: Attending Physician Name
Loop: 2310.A
Max. Use: 1
X12 Purpose: To supply the full name of an individual or organizational entity
Usage: Mandatory
Example: NM1*71*1*ZUBELDIA*KEPA****UP*C12345~
Comments: The Physician must be identified by name (NM103) and by Identification Number (NM108 and NM109) according to Billing Instructions.

Syntax Note: P0809 - If either NM108 or NM109 is present, then the other must be present.

Semantic Note: NM102 qualifies NM103.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
NM101 0098 ID 2 2 M	Entity Identifier Code Code identifying an organizational entity, a physical location, or an individual Codes: 71 Attending Physician Physician present when medical services are performed	
NM102 1065 ID 1 1 M	Entity Type Qualifier Code qualifying the type of entity. Codes: 1 Person	
NM103 1035 AN 1 35 O	Name Last or Organization Name Attending Physician Last Name Individual last name or organizational name	80-09 Also maps to 71-18 if you are creating this attachment
NM104 1036 AN 1 25 O	Name First Attending Physician First Name Individual first name. This is the first name of the attending physician.	80-09 Also maps to 71-19 if you are creating this attachment
NM105 1037 AN 1 25 O	Name Middle Attending Physician Middle Name Individual middle name or initial. This is the middle name or initial of the attending physician.	80-09 Also maps to 71-20 if you are creating this attachment

NM106 1038	Name Prefix Not Used.	
NM107 1039	Name Suffix Not Used.	
NM108 0066 ID 1 2 C	Identification Code Qualifier Code designating the system/method of code structure used for Identification Code (67). Codes: UP Unique Physician Identification Number (UPIN) Number assigned to the provider by the National Registry for Medicare identification purposes	80-04
NM109 0067 AN 2 20 C	Identification Code Attending Physician UPIN Code identifying a party or other code.	80-05

X12 Segment Name: N4 Geographic Location
Name: Patient City, State, ZIP
Loop: 2310.A
Max. Use: 1
X12 Purpose: To specify the geographic place of the named party
Usage: Optional
Example: N4*****75122~

Syntax Note: C0605 - If N406 is present, then N405 must be present.

X12 Comment: A combination of either N401 through N404 (or N405 and N406) may be adequate to specify a location.
X12 Comment: N402 is required only if city name (N401) is in the USA or Canada.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
N401 0019	City Name Not Used.	
N402 0156	State or Province Code Not Used.	
N403 0116 ID 3 11 O	Postal Code Physician ZIP Code Code defining international postal zone code excluding punctuation and blanks (zip code for United States). The ZIP Code of the attending physician. Use only if you are mapping from 71-23 for home health.	71-21
N404 0026	Country Code Not Used.	
N405 0309	Location Qualifier Not Used.	
N406 0310	Location Identifier Not Used.	

X12 Segment Name: NM1 Individual or Organizational Name
Name: Operating Physician Name
Loop: 2310.B
Max. Use: 1
X12 Purpose: To supply the full name of an individual or organizational entity
Usage: Optional
Example: NM1*72*1*ZUBELDIA*KEPA****UP*A01234~
Comments: The Physician must be identified by name (NM103) and/or by Identification Number (NM108 and NM109) according to Billing Instructions.

Syntax Note: P0809 - If either NM108 or NM109 is present, then the other must be present.

Semantic Note: NM102 qualifies NM103.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
NM101 0098 ID 2 2 M	Entity Identifier Code Code identifying an organizational entity, a physical location, or an individual Codes: 72 Operating Physician Doctor who performs a surgical procedure	
NM102 1065 ID 1 1 M	Entity Type Qualifier Code qualifying the type of entity. Codes: 1 Person	
NM103 1035 AN 1 35 O	Name Last or Organization Name Operating Physician Last Name Individual last name or organizational name This field only maps to record 81 field 7 when an ordering physician is associated with the claim. Ordering physician is sent in the 2310 loop with the NM101 code of "DK"	80-10 positions 116-131
NM104 1036 AN 1 25 O	Name First Operating Physician First Name Individual first name.	80-10 positions 132-139
NM105 1037 AN 1 25 O	Name Middle Operating Physician Middle Name Individual middle name or initial.	80-10 position 140

NM106 1038	Name Prefix Not Used.	
NM107 1039	Name Suffix Not Used.	
NM108 0066 ID 1 2 C	Identification Code Qualifier Code designating the system/method of code structure used for Identification Code (67). Codes: UP Unique Physician Identification Number (UPIN) Number assigned to the provider by the National Registry for Medicare identification purposes	80-04
NM109 0067 AN 2 20 C	Identification Code Operating Physician UPIN Code identifying a party or other code.	80-06

X12 Segment Name: NM1 Individual or Organizational Name
Name: Other Physician Name
Loop: 2310.C Repeat 2
Max. Use: 1
X12 Purpose: To supply the full name of an individual or organizational entity
Usage: Optional
Example: NM1*73*1*SMITH*JOHN*I***UP*B12365~
Comments: The Physician must be identified by name (NM103) and/or by Identification Number (NM108 and NM109) according to Billing Instructions.

Syntax Note: P0809 - If either NM108 or NM109 is present, then the other must be present.

Semantic Note: NM102 qualifies NM103.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
NM101 0098 ID 2 2 M	Entity Identifier Code Code identifying an organizational entity, a physical location, or an individual Codes: 73 Other Physician Physician not one of the other specified choices	
NM102 1065 ID 1 1 M	Entity Type Qualifier Code qualifying the type of entity. Codes: 1 Person	
NM103 1035 AN 1 35 O	Name Last or Organization Name Other Physician Last Name Individual last name or organizational name	80-11, 80-12
NM104 1036 AN 1 25 O	Name First Other Physician First Name Individual first name.	80-11, 80-12
NM105 1037 AN 1 25 O	Name Middle Other Physician Middle Name Individual middle name or initial.	80-11, 80-12
NM106 1038	Name Prefix Not Used.	

NM107 1039	Name Suffix Not Used.	
NM108 0066 ID 1 2 C	Identification Code Qualifier Code designating the system/method of code structure used for Identification Code (67). Codes: UP Unique Physician Identification Number (UPIN) Number assigned to the provider by the National Registry for Medicare identification purposes	80-04
NM109 0067 AN 2 20 C	Identification Code Other Physician UPIN Code identifying a party or other code.	80-07, 80-08

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X12 Segment Name: LE Loop Trailer
Loop: 2300
Max. Use: 1
X12 Purpose: To indicate that the loop immediately preceding this segment is complete
Usage: Optional
Example: LE*2310~
Comments: This segment MUST be used once, and only once, if NM1 at position 250 is used, regardless of the number of repetitions of loop 2310.

Semantic Note: One loop may be nested contained within another loop, provided the inner nested loop terminates before the other loop. When specified by the standards setting body as "mandatory", this segment in combination with "LS", must be used. It is not to be used if not specifically set forth for use. The loop identifier in the loop header and trailer must be identical. The value for the identifier is the loop ID of the required loop beginning segment. The loop ID number is given on the transaction set diagram in the appropriate ASC X12 version/release.

X12 Comment: See Figures Appendix for an explanation of the use of the LE and LS segments.

Element Attributes	Data Element Usage
LE01 0447 AN 1 4 M	Loop Identifier Code The loop ID number given on the transaction set diagram is the value for this data element in segments LS and LE Use 2310

X12 Segment Name: LS Loop Header
Loop: 2300
Max. Use: 1
X12 Purpose: To indicate that the next segment begins a loop
Usage: Optional
Example: LS*2320~
Comments: This segment MUST be used once if additional insurance other than Medicare needs to be reported. Medicare should never be sent in this loop. In cases where Medicare is secondary, the primary payor would be reported in 2320.

Semantic Note: One loop may be nested contained within another loop, provided the inner nested loop terminates before the outer loop. When specified by the standard setting body as "mandatory", this segment in combination with "LE", must be used. It is not to be used if not specifically set forth for use. The loop identifier in the loop header and trailer must be identical. The value for the identifier is the loop ID of the required loop segment. The loop ID number is given on the transaction set diagram in the appropriate ASC X12 version/release.

X12 Comment: See Figures Appendix for an explanation of the use of the LS and LE segments.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
LS01 0447 AN 1 4 M	Loop Identifier Code The loop ID number given on the transaction set diagram is the value for this data element in segments LS and LE Use 2320	

X12 Segment Name: SBR Subscriber Information
Name: Additional Payor Information
Loop: 2320
Max. Use: 1
X12 Purpose: To record information specific to the primary insured and the insurance carrier for that insured
Purpose: To supply information about insurance which pays after Medicare.
Usage: Conditional
Example: SBR*S*18*0001234*GOLDEN GAP~
Comments: Required when the Medicare patient has other insurance.
See Section E for a detailed mapping of this segment.
If there is more than one additional insurance, repeat loops 2320 and 2330. When Medicare is not the primary payer, report primary payer in this loop and repeat if necessary for other insurance. Medicare should not be reported in this loop.

Semantic Note: SBR02 specifies the relationship to the person insured.
Semantic Note: SBR03 is policy or group number.
Semantic Note: SBR04 is plan name.
Semantic Note: SBR07 is destination payer code. A "Y" value indicates the payer is the destination payer. An "N" value indicates the payer is not the destination payer.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
SBR01 1138 ID 1 1 M	Payer Responsibility Sequence Number Code Supplementary Payor Responsibility Sequence Code Code indentifying the insurance carrier's level of responsibility for a payment of a claim Code identifying the supplementary payor's level of responsibility for payment of the claim. Codes: P Primary S Secondary T Tertiary	30-02 UB92 Code "1" UB92 Code "2" UB92 Code "3"
SBR02 1069 ID 2 2 M	Individual Relationship Code Patient Relationship to Insured Code indicating the relationship between two individuals or entities. Code specifying the relationship of the Medicare patient to the insured. Codes: 18 Self 01 Spouse	30-18 UB-92 Code "01" UB-92 Code "02"

	19 Child Dependent between the ages of 0 and 19. Age qualifications may vary depending on policy	UB-92 Code "03"
	21 Unknown	UB-92 Code "09"

SBR03 0127 Reference Number 30-10
AN 1 30 C Supplementary Payor Group or Number
Reference number or identification number as defined for a particular Transaction Set, or as specified by the Reference Number Qualifier.
Identification number of the insured's group or policy as assigned by the supplementary payor.

SBR04 0093 Name 30-11
AN 1 35 O Supplementary Payor Group Name
Free-form name.
Name of the insured's group as known to the supplementary payor.

SBR05 1336 Insurance Type Code
Not Used.

SBR06 1143 Coordination of Benefits Code
Not Used.

SBR07 1073 Yes/No Condition or Response Code
Not Used.

SBR08 0584 Employment Status Code 30-19
ID 2 2 O Employment Status Code
Code showing the general employment status of an employee/claimant.
Codes: (not all codes map)

AO Active Military - Overseas	
AU Active Military - USA	UB92 Code "6"
FT Full-time	UB92 Code "1"
NE Not Employed	UB92 Code "3"
PT Part-time	UB92 Code "2"
RT Retired	UB92 Code "5"
SE Self-Employed	UB92 Code "4"
UK Unknown	UB92 Code "9"

SBR09 1032 Claim Filing Indicator Code
Not Used.

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X12 Segment Name: AMT Monetary Amount
Name: Payor Amount Paid
Loop: 2320
Max. Use: 15
X12 Purpose: To indicate the total monetary amount.
Usage: Optional
Example: AMT*D*150~
Comments: Payor amount paid for this claim.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
AMT01 0522 ID 1 2 M	Amount Qualifier Code Code to qualify amount Codes: D Payor Amount Paid	
AMT02 0782 R 1 15 M	Monetary Amount Monetary amount.	30-25
AMT03 0478	Credit/Debit Flag Code Not Used.	

X12 Segment Name: AMT Monetary Amount
Name: Estimated Amount Due
Loop: 2320
Max. Use: 15
X12 Purpose: To indicate the total monetary amount.
Usage: Optional
Example: AMT*C5*575~

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
AMT01 0522 ID 1 2 M	Amount Qualifier Code Code to qualify amount Codes: C5 Claim Amount Due - Estimated Approximate value rightfully belonging to the individual	
AMT02 0782 R 1 15 M	Monetary Amount Monetary amount.	30-26
AMT03 0478	Credit/Debit Flag Code Not Used.	

X12 Segment Name: DMG Demographic Information
Name: Other Insured Date of Birth and Sex
Loop: 2320
Max. Use: 1
X12 Purpose: To supply demographic information
Usage: Conditional
Example: DMG*D8*18961105*F~
Comments: Required when the Medicare patient is not the person insured by the supplementary payor.

Syntax Note: P0102 - If either DMG01 or DMG02 is present, then the other must be present.

Semantic Note: DMG02 is the date of birth.
Semantic Note: DMG07 is the country of citizenship.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
DMG01 1250 ID 2 3 C	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format. Codes: D8 Date Expressed in Format CCYYMMDD	
DMG02 1251 AN 1 35 C	Date Time Period Other Insured Date of Birth Expression of a date, a time, or range of dates, times or dates and times.	
DMG03 1068 ID 1 1 M	Gender Code Other Insured Sex Code indicating the sex of the individual. Codes: F Female M Male U Unknown	30-15
DMG04 1067	Marital Status Code Not Used.	
DMG05 1109	Race or Ethnicity Code Not Used.	
DMG06 1066	Citizenship Status Code Not Used.	

DMG07 0026 Country Code
Not Used.

DMG08 0659 Basis of Verification Code
Not Used.

X12 Segment Name: OI Other Health Insurance Information
Name: Supplementary Payor Type of Insurance
Loop: 2320
Max. Use: 1
X12 Purpose: To specify information associated with other health insurance coverage
Purpose: To specify the supplementary payor type of insurance.
This segment is required when reporting additional insurance.
Usage: Conditional
Example: OI*CI~

Semantic Note: OI03 is assignment of benefits indicator. A "Y" value indicates insured or authorized person authorizes benefits to be assigned to the provider. An "N" value indicates benefits have not been assigned to the provider.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
OI01 1032 ID 1 2 M	Claim Filing Indicator Code Supplementary Payor Type of Insurance Code identifying type of claim Claim filing indicator code. Codes: (Not all codes map) BL Blue Cross/Blue Shield CH CHAMPUS CI Commercial Insurance Co. FI Federal Employees Program HM Health Maintenance Organization MC Medicaid MH Managed Care Non-HMO OF Other Federal Program SA Self-administered Group TV Title V VA Veteran Administration Plan WC Workers' Compensation Health Claim	30-04 UB92 Code "G" UB92 Code "H" UB92 Code "F" UB92 Code "E" UB92 Code "I" UB92 Code "D" UB92 Code "I" UB92 Code "E" UB92 Code "A" UB92 Code "I" UB92 Code "I" UB92 Code "B"
OI02 1383	Claim Submission Reason Code Not Used.	
OI03 1073 ID 1 1 O	Yes/No Condition or Response Code Assignment of Benefits Indicator Code indicating a Yes or No condition or response. A "Y" value indicates insured or authorized person authorizes benefits to be assigned to the provider. A "N" indicates benefits have not been assigned to the provider. Codes: Y Yes N No	30-17

OI04 1351 Patient Signature Source Code
Not Used.

OI05 1360 Provider Agreement Code
Not Used.

OI06 1363 Release of Information Code 30-16
ID 1 1 O Release of information Indicator
Code indicating whether the provider has on file a signed statement by the patient authorizing the release of medical data to other organizations
Codes:
M The Provider has Limited or Restricted Ability to Release Data Related to a Claim UB-92 CODE R=M
N No, Provider is Not Allowed to Release Data UB-92 CODE N=N
Y Yes, Provider has a Signed Statement Permitting Release of Medical Billing Data Related to a Claim UB-92 CODE Y=Y

X12 Segment Name: NM1 Individual or Organizational Name
Name: Supplementary Payor Name
Loop: 2330
Max. Use: 10
X12 Purpose: To supply the full name of an individual or organizational entity
Purpose: This segment is required when reporting additional insurance.
Usage: Conditional
Example: NM1*PR*2*NATIONAL RETIREMENT*****PI*NR002~

Syntax Note: P0809 - If either NM108 or NM109 is present, then the other must be present.

Semantic Note: NM102 qualifies NM103.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
NM101 0098 ID 2 2 M	Entity Identifier Code Code identifying an organizational entity, a physical location, or an individual Codes: PR Payer	
NM102 1065 ID 1 1 M	Entity Type Qualifier Code qualifying the type of entity. Codes: 2 Non-Person Entity	
NM103 1035 AN 1 35 C	Name Last or Organization Name Supplementary Payor Name Individual last name or organizational name Payor Name required if NM109 is not a Intermediary assigned code.	30-08
NM104 1036	Name First Not Used.	
NM105 1037	Name Middle Not Used.	
NM106 1038	Name Prefix Not Used.	
NM107 1039	Name Suffix Not Used.	

NM108 0066 ID 1 2 C	Identification Code Qualifier Code designating the system/method of code structure used for Identification Code (67). Codes: PI Payor Identification ZZ Mutually Defined	30-8a UB-92 code - spaces UB-92 code - XV
NM109 0067 AN 2 20 C	Identification Code Supplementary Payor Identification Number. Code identifying a party or other code. Intermediary assigned code.	30-05, 30-06

X12 Segment Name: REF Reference Numbers
Name: Treatment Authorization Number
Loop: 2330
Max. Use: 3
X12 Purpose: To specify identifying numbers.
Usage: Optional
Example: REF*BB*9300007891~

Syntax Note: R0203 - At least one of REF02 or REF03 must be present.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
REF01 0128 ID 2 2 M	Reference Number Qualifier Code qualifying the Reference Number. Codes: BB Authorization Number Proves that permission was obtained to provide a service	
REF02 0127 AN 1 30 M	Reference Number Treatment Authorization Number Reference number or identification number as defined for a particular Transaction Set, or as specified by the Reference Number Qualifier.	40-05 WHEN SBR01=P 40-06 WHEN SBR01=S 40-07 WHEN SBR01=T
REF03 0352	Description Not Used.	

X12 Segment Name: REF Reference Numbers
Name: Provider Identification Number
Loop: 2330
Max. Use: 3
X12 Purpose: To specify identifying numbers.
Usage: Optional
Example: REF*G2*731234567~

Syntax Note: R0203 - At least one of REF02 or REF03 must be present.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
REF01 0128 ID 2 2 M	Reference Number Qualifier Code qualifying the Reference Number. Codes: G2 Provider Commercial Number A unique number assigned to a provider by a commercial insurer	
REF02 0127 AN 1 30 M	Reference Number Provider Identification Number Reference number or identification number as defined for a particular Transaction Set, or as specified by the Reference Number Qualifier.	30-24
REF03 0352	Description Not Used.	

X12 Segment Name: REF Reference Numbers
Name: Original ICN/DCN Number
Loop: 2330
Max. Use: 3
X12 Purpose: To specify identifying numbers.
Usage: Optional
Example: REF*F8*931278760100~
Comments: This segment is required when reporting additional insurance.

Syntax Note: R0203 - At least one of REF02 or REF03 must be present.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
REF01 0128 ID 2 2 M	Reference Number Qualifier Code qualifying the Reference Number. Codes: F8 Original Reference Number	
REF02 0127 AN 1 30 M	Reference Number Original ICN/DCN Number Reference number or identification number as defined for a particular Transaction Set, or as specified by the Reference Number Qualifier.	31-14
REF03 0352	Description Not Used.	

X12 Segment Name: NM1 Individual or Organizational Name
Name: Other Insured Name
Loop: 2330
Max. Use: 1
X12 Purpose: To supply the full name of an individual or organizational entity
Usage: Conditional
Example: NM1*IL*1*ZUBELDIA*LESLIE*B**C1*464675489~
Comments: Required when the Medicare patient is not the person insured by the supplementary payor or if there is a different insured identification number.

Syntax Note: P0809 - If either NM108 or NM109 is present, then the other must be present.

Semantic Note: NM102 qualifies NM103.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
NM101 0098 ID 2 2 M	Entity Identifier Code Code identifying an organizational entity, a physical location, or an individual Codes: IL Insured or Subscriber	
NM102 1065 ID 1 1 M	Entity Type Qualifier Code qualifying the type of entity. Codes: 1 Person	
NM103 1035 AN 1 35 M	Name Last or Organization Name Other Insured Last Name Individual last name or organizational name	30-12
NM104 1036 AN 1 25 M	Name First Other Insured First Name Individual first name.	30-13
NM105 1037 AN 1 25 O	Name Middle Other Insured Middle Initial Individual middle name or initial.	30-14
NM106 1038	Name Prefix Not Used.	
NM107 1039	Name Suffix	

Not Used.

NM108 0066 ID 1 2 C	Identification Code Qualifier Code designating the system/method of code structure used for Identification Code (67). Codes: C1 Insured or Subscriber	
NM109 0067 AN 2 20 C	Identification Code Other Insured Identification Number. Code identifying a party or other code. Other insured's unique identification number.	30-07

X12 Segment Name: N3 Address Information
Name: Other Insured Address
Loop: 2330
Max. Use: 2
X12 Purpose: To specify the location of the named party
Usage: Optional
Example: N3*44 W1500 SOUTH ST~

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
N301 0166 AN 1 35 M	Address Information Other Insured Address Line 1 Address information	31-04
N302 0166 AN 1 35 O	Address Information Other Insured Address Line 2 Address information	31-05

X12 Segment Name: N4 Geographic Location
Name: Other Insured City, State, ZIP
Loop: 2330
Max. Use: 1
X12 Purpose: To specify the geographic place of the named party
Usage: Optional
Example: N4*ANYTOWN*TX*75122~

Syntax Note: C0605 - If N406 is present, then N405 must be present.

X12 Comment: A combination of either N401 through N404 (or N405 and N406) may be adequate to specify a location.
X12 Comment: N402 is required only if city name (N401) is in the USA or Canada.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
N401 0019 AN 2 30 O	City Name Other Insured City Free-form text for city name.	31-06
N402 0156 ID 2 2 O	State or Province Code Other Insured State Code (Standard State/Province) as defined by appropriate government agency.	31-07
N403 0116 ID 3 11 O	Postal Code Other Insured ZIP Code defining international postal zone code excluding punctuation and blanks (zip code for United States).	31-08
N404 0026	Country Code Not Used.	
N405 0309	Location Qualifier Not Used.	
N406 0310	Location Identifier Not Used.	

X12 Segment Name: NM1 Individual or Organizational Name
Name: Subscriber's Employer Name
Loop: 2330
Max. Use: 1
X12 Purpose: To supply the full name of an individual or organizational entity
Usage: Conditional
Example: NM1*84*2*ACME BRICK~
Comments: Required when the payor is the subscriber's employer group insurance.

Syntax Note: P0809 - If either NM108 or NM109 is present, then the other must be present.

Semantic Note: NM102 qualifies NM103.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
NM101 0098 ID 2 2 M	Entity Identifier Code Code identifying an organizational entity, a physical location, or an individual Codes: 84 Subscriber's Employer	
NM102 1065 ID 1 1 M	Entity Type Qualifier Code qualifying the type of entity. Codes: 2 Non-Person Entity	
NM103 1035 AN 1 35 M	Name Last or Organization Name Subscriber's Employer Name Individual last name or organizational name	31-09
NM104 1036	Name First Not Used.	
NM105 1037	Name Middle Not Used.	
NM106 1038	Name Prefix Not Used.	
NM107 1039	Name Suffix Not Used.	

NM108 0066 Identification Code Qualifier
Not Used.

NM109 0067 Identification Code
Not Used.

X12 Segment Name: N3 Address Information
Name: Subscriber's Employer Address
Loop: 2330
Max. Use: 2
X12 Purpose: To specify the location of the named party
Usage: Optional
Example: N3*Industrial Drive~

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
N301 0166 AN 1 35 M	Address Information Employer Address Line 1 Address information	31-10
N302 0166	Address Information Not Used.	

X12 Segment Name: N4 Geographic Location
Name: Subscriber's Employer City, State, ZIP
Loop: 2330
Max. Use: 1
X12 Purpose: To specify the geographic place of the named party
Usage: Optional
Example: N4*Somewhere*TX*75122~

Syntax Note: C0605 - If N406 is present, then N405 must be present.

X12 Comment: A combination of either N401 through N404 (or N405 and N406) may be adequate to specify a location.
X12 Comment: N402 is required only if city name (N401) is in the USA or Canada.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
N401 0019 AN 2 30 O	City Name Subscriber's Employer City Free-form text for city name.	31-11
N402 0156 ID 2 2 O	State or Province Code Subscriber's Employer State Code (Standard State/Province) as defined by appropriate government agency.	31-12
N403 0116 ID 3 11 O	Postal Code Subscriber's Employer ZIP Code defining international postal zone code excluding punctuation and blanks (zip code for United States).	31-13
N404 0026	Country Code Not Used.	
N405 0309	Location Qualifier Not Used.	
N406 0310	Location Identifier Not Used.	

X12 Segment Name: NM1 Individual or Organizational Name
Name: Other Employer Name
Loop: 2330
Max. Use: 4
X12 Purpose: To supply the full name of an individual or organizational entity
Usage: Conditional
Example: NM1*ES*2*BROADWAY FORD~
Comments: This loop may be repeated four times for other employers.

Syntax Note: P0809 - If either NM108 or NM109 is present, then the other must be present.

Semantic Note: NM102 qualifies NM103.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
NM101 0098 ID 2 2 M	Entity Identifier Code Code identifying an organizational entity, a physical location, or an individual Codes: ES Employer Name	
NM102 1065 ID 1 1 M	Entity Type Qualifier Code qualifying the type of entity. Codes: 2 Non-Person Entity	
NM103 1035 AN 1 35 C	Name Last or Organization Name Other Employer Name Individual last name or organizational name	21-04, 21-11
NM104 1036	Name First Not Used.	
NM105 1037	Name Middle Not Used.	
NM106 1038	Name Prefix Not Used.	
NM107 1039	Name Suffix Not Used.	
NM108 0066	Identification Code Qualifier	

Not Used.

NM109 0067 Identification Code
Not Used.

X12 Segment Name: N3 Address Information
Name: Other Employer Address
Loop: 2330
Max. Use: 2
X12 Purpose: To specify the location of the named party
Usage: Optional
Example: N3*Industrial Drive~

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
N301 0166 AN 1 35 M	Address Information Employer Address Line 1 Address information	21-05, 21-12
N302 0166	Address Information Not Used.	

X12 Segment Name: N4 Geographic Location
Name: Other Employer City, State, ZIP
Loop: 2330
Max. Use: 1
X12 Purpose: To specify the geographic place of the named party
Usage: Optional
Example: N4*Somewhere*TX*75122~

Syntax Note: C0605 - If N406 is present, then N405 must be present.

X12 Comment: A combination of either N401 through N404 (or N405 and N406) may be adequate to specify a location.
X12 Comment: N402 is required only if city name (N401) is in the USA or Canada.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
N401 0019 AN 2 30 O	City Name Other Employer City Free-form text for city name.	21-06, 21-13
N402 0156 ID 2 2 O	State or Province Code Other Employer State Code (Standard State/Province) as defined by appropriate government agency.	21-07, 21-14
N403 0116 ID 3 11 O	Postal Code Other Employer ZIP Code defining international postal zone code excluding punctuation and blanks (zip code for United States).	21-08, 21-15
N404 0026	Country Code Not Used.	
N405 0309	Location Qualifier Not Used.	
N406 0310	Location Identifier Not Used.	

X12 Segment Name: REF Reference Numbers
Name: Employment Status Code
Loop: 2330
Max. Use: 3
X12 Purpose: To specify identifying numbers.
Usage: Optional
Example: REF*ZZ*FT~
Comments: This segment is required when reporting additional insurance.

Syntax Note: R0203 - At least one of REF02 or REF03 must be present.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
REF01 0128 ID 2 2 M	Reference Number Qualifier Code qualifying the Reference Number. Codes: ZZ Mutually Defined	
REF02 0127 AN 1 30 M	Reference Number Other Employment Status Code Reference number or identification number as defined for a particular Transaction Set, or as specified by the Reference Number Qualifier. AO Active Military - Overseas AU Active Military - USA FT Full Time NE Not Employed PT Part Time RT Retired SE Self-Employed UK Unknown	21-09, 21-16 (Not all codes map) UB92 Code "1" UB92 Code "3" UB92 Code "2" UB92 Code "5" UB92 Code "4" UB92 Code "9"
REF03 0352 AN 1 80 C	Description A free-form description to clarify the related data elements and their content. Not Used.	

SEGMENT: NM1 Individual or Organizational Name
NAME: SUPPLEMENTARY PAYOR NAME (CONTRACT NUMBER)
LOOP: 2330 Repeat: 10
USAGE: Optional
MAX USE: 1
SYNTAX: 1. P0809--If either NM108 or NM109 is present, then the other is required.
SEMANTIC: 1. NM102 qualifies NM103.
EXAMPLE: NM1*PR*2******ZY*NR002~

DATA ELEMENT SUMMARY ----------

NM101 98 ENTITY IDENTIFIER CODE
M ID 2/2 Code identifying an organizational entity, a physical location, or an individual
Code:
PR Payer

NM102 1065 ENTITY TYPE QUALIFIER
M ID 1/1 Code qualifying the type of entity.
2 Non-Person Entity

NM103 1035 NAME LAST OR ORGANIZATION NAME
O AN 1/35 Individual last name or organizational name
Not Used

NM104 1036 NAME FIRST
O AN 1/25 Individual first name.
Not Used

NM105 1037 NAME MIDDLE
O AN 1/25 Individual middle name or initial.
Not Used

NM106 1038 NAME PREFIX
O AN 1/10 Prefix to individual name.
Not Used

NM107 1039 NAME SUFFIX
O AN 1/10 Suffix to individual name.
Not Used

NM108 66 IDENTIFICATION CODE QUALIFIER
C ID ½ Code designating the system/method of code structure used for Identification Code (67).
Payer Identification Indicator
ZY Temporary Identification Number (Contract Number)

NM109 67 IDENTIFICATION CODE UB-92 v5.0 31-15
C AN 2/20 Code identifying a party or other code.
Supplementary Payor Identification

X12 Segment Name: LE Loop Trailer
Loop: 2300
Max. Use: 1
X12 Purpose: To indicate that the loop immediately preceding this segment is complete
Usage: Optional
Example: LE*2320~
Comments: This segment MUST be used once, and only once, if SBR at position 290 is used, regardless of the number of repetitions of loop 2500.

Semantic Note: One loop may be nested contained within another loop, provided the inner nested loop terminates before the other loop. When specified by the standards setting body as "mandatory", this segment in combination with "LS", must be used. It is not to be used if not specifically set forth for use. The loop identifier in the loop header and trailer must be identical. The value for the identifier is the loop ID of the required loop beginning segment. The loop ID number is given on the transaction set diagram in the appropriate ASC X12 version/release.

X12 Comment: See Figures Appendix for an explanation of the use of the LE and LS segments.

Element Attributes	Data Element Usage
LE01 0447 AN 1 4 M	Loop Identifier Code The loop ID number given on the transaction set diagram is the value for this data element in segments LS and LE Use 2320

X12 Segment Name: LX Assigned Number
Loop: 2400 Repeat >1
Max. Use: 1
X12 Purpose: To reference a line number in a transaction set.
Usage: Mandatory
Example: LX*1~

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
LX01 0554 N0 1 6 M	Assigned Number Number assigned for differentiation within a transaction set. Service line number, beginning with 1, incremented by 1 for each service line. The maximum number of service lines per claim is determined by the Intermediary receiving the claim.	

X12 Segment Name: SV2 Institutional Service
Loop: 2400
Max. Use: 1
X12 Purpose: To specify the claim service detail for a Health Care institution
Usage: Mandatory
Example: SV2*0305*HC:99211*25*UN*5~

Syntax Note: P0405 - If either SV204 or SV205 is present, then the other must be present.

Semantic Note: SV201 is revenue code.
Semantic Note: SV203 is submitted charge amount.
Semantic Note: SV207 is non-covered charge amount.
Semantic Note: SV208 is detail service line indicator. A "Y" value indicates a detail service line. An "N" value indicates a summary service line.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
SV201 0234 AN 1 40 M	Product/Service ID Revenue Center Code Identifying number for a product or service.	50-04 50-11, 50-12, 50-13 60-04, 60-13, 60-14 61-04, 61-14, 61-15
SV202 C003 Composit C	Composite Medical Procedure Identifier To identify a medical procedure by its standardized codes and applicable modifiers	
*-01 0235 ID 2 2 M	Product/Service ID Qualifier Code identifying the type/source of the descriptive number used in Product/Service ID (234). Codes: HC Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes HCFA coding scheme to group procedure(s) performed on an outpatient basis for payment to hospital under Medicare. Primarily used for ambulatory surgical and other diagnostic departments CJ Current Procedural Terminology (CPT) Codes Published by the AMA. It is a listing of descriptive terms and identifying codes for reporting medical services and procedures	

	performed by physicians. The uniform language accurately designates medical, surgical, and diagnostic services, and thereby provides reliable communications among physicians, patients, and payers	
	ZZ Mutually defined. Health Insurance Prospective Payment System (HIPPS) Skilled Nursing Facility Rate Code used only be Skilled Nursing Facilities when required to identify the HIPPS code associated with revenue code 0022. HIPPS codes are available from the: Division of Institutional Claims Processing (PPAG, CHPP), Health Care Financing Administration, 7500 Security Blvd (C4), Baltimore Maryland 21244-1850."	
*-02 0234	Product/Service ID or HIPPS Code	60-05,13,14, 61-05,14,15
AN 1 40 M	HCPCS Procedure Code Identifying number for a product or service.	
*-03 1339	Procedure Modifier	60-06,13,14, 61-06,14,15
AN 2 2 O	Modifier 1 This identifies special circumstances related to the performance of the service, as defined by trading partners A code to identify special circumstances related to the performance of the service. Enter the first Procedure modifier, if applicable.	
*-04 1339	Procedure Modifier	60-07,13,14, 61-07,14,15
AN 2 2 O	Modifier 2 This identifies special circumstances related to the performance of the service, as defined by trading partners A code to identify special circumstances related to the performance of the service. Enter the first Procedure modifier, if applicable.	
*-05 1339	Procedure Modifier Not Used.	
*-06 1339	Procedure Modifier Not Used.	
*-07 0352	Description Not Used.	
SV203 0782	Monetary Amount	50-07, 11, 12, 13, 60-09, 13, 14, 61-10,
R 1 15 O	Total Charges Monetary amount. Submitted charge amount. The charge related to this service. Submitted charge amount in dollars. Optionally may include cents. The decimal point	14, 15

	is only required when sending cents. Leading and trailing zeroes should not be used. Use "25" instead of "25.00" or "25.1" instead of "25.10"	
SV204 0355 ID 2 2 C	Unit or Basis for Measurement Code Code specifying the units in which a value is being expressed, or manner in which a measurement has been taken Codes: DA Days UN Unit	
SV205 0380 R 1 15 C	Quantity Numeric value of quantity. The number of services rendered in the units described in SV204. The decimal point is ONLY required when sending tenths of unit.	50-06, 50-11, 50-12, 50-13, 60-08, 60-13, 60-14, 61-08, 61-14, 61-15
SV206 1371 R 1 10 O	Unit Rate Accommodations Rate The rate per unit of associate revenue for hospital accommodation	50-05
SV207 0782 R 1 15 O	Monetary Amount Non-Covered Charges Monetary amount. Actual charge amount in dollars. Optionally may include cents. The decimal point is ONLY required when sending cents. Leading and trailing zeroes should not be used. Use "25" instead of "25.00" or "25.1" instead of "25.10"	50-08, 50-11, 50-12, 50-13, 60-10, 60-13, 60-14, 61-11, 61-14, 61-15
SV208 1073	Yes/No Condition or Response Code Not Used.	
SV209 1345	Nursing Home Residential Status Code Not Used.	
SV210 1337	Level of Care Code Not Used.	

X12 Segment Name: DTP Date or Time or Period
Name: Outpatient Service Date or Inpatient Health Insurance Prospective Payment System (HIPPS) Assessment Date
Loop: 2400
Max. Use: 3
X12 Purpose: To specify any or all of a date, a time, or a time period
Usage: Conditional - Required for Skilled Nursing Facility (SNF) claims. When the revenue code is 002X, the HIPPS assessment date will be placed in DTP03.
Example: DTP*472*D8*19930122~

Semantic Note: DTP02 is the date or time or period format that will appear in DTP03.

Element Attributes	Data Element Usage	UB92 EMC VER.5.0 Mapping
DTP01 0374 ID 3 3 M	Date/Time Qualifier Code specifying type of date or time, or both date and time. Codes: 472 Service	
DTP02 1250 ID 2 3 M	Date Time Period Format Qualifier Code indicating the date format, time format, or date and time format. Codes: D8 Date Expressed in Format CCYYMMDD	
DTP03 1251 AN 1 35 M	Date Time Period Date of Service Expression of a date, a time, or range of dates, times or dates and times.	61-12, 61-14, 61-15 (outpatient) 60-12, 60-13, 60-14 (HIPPS)

X12 Segment Name: SE Transaction Set Trailer
Loop: ----
Max. Use: 1
X12 Purpose: To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments).
Usage: Mandatory
Example: SE*1230*112233~

X12 Comment: SE is the last segment of each transaction set.

Element Attributes	Data Element Usage
SE01 0096 N0 1 10 M	Number of Included Segments Total number of segments included in a transaction set including ST and SE segments.
SE02 0329 AN 4 9 M	Transaction Set Control Number Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set

X12 Segment Name: GE Functional Group Trailer
Loop: ----
Max. Use: 1
X12 Purpose: To indicate the end of a functional group and to provide control information
Usage: Mandatory
Example: GE*1*1~

Semantic Note: The data interchange control number GE02 in this trailer must be identical to the same data element in the associated Functional Header GS06.

X12 Comment: The use of identical data interchange control numbers in the associated functional group header and trailer is designed to maximize functional group integrity. The control number is the same as that used in the corresponding header.

Element Attributes	Data Element Usage
GE01 0097 N0 1 6 M	Number of Transaction Sets Included Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element.
GE02 0028 N0 1 9 M	Group Control Number Assigned number originated and maintained by the sender. The Group Control Number, GE02, must be identical to the one found in the associated functional header GS06.

X12 Segment Name: IEA Interchange Control Trailer
Loop: ----
Max. Use: 1
X12 Purpose: To define the end of an interchange of zero or more functional groups and interchange-related control segments
Usage: Mandatory
Example: IEA*1*000000905~

Element Attributes	Data Element Usage
IEA01 I16 N0 1 5 M	Number of Included Functional Groups A count of the number of functional groups included in an interchange
IEA02 I12 N0 9 9 M	Interchange Control Number A control number assigned by the interchange sender The Interchange Control Number, IEA02, must be identical to the one found in the associated Interchange Header ISA13.

UB-92 Data Dictionary

In most cases, these definitions are taken word for word from the UB-92 Version 5.0. The fields are listed alphabetically.
Definitions of the 837 data elements can be found in the Implementation Detail in Part IV.
UB-92 mappings are also shown in the Implementation Detail, along with the attributes of the 837 elements.

Accident Hour - The hour when the accident occurred that necessitated medical treatment. Shown as value code 45 and amount.

Accommodations Days -A numeric count of accommodations days in accordance with payer instructions. Includes UB-92 revenue codes 10X through 21X.

Accommodations Non-Covered Charges - Accommodations charges pertaining to the related UB-92 Accommodations revenue code that are not covered by the primary payor as determined by the provider.

Accommodations Rate - Per diem rate for related UB-92 accommodations revenue codes.

Accommodations Revenue Code - UB-92 revenue center code for the accommodation provided. Includes codes 10X through 21X.

Accommodations Total Charges - Total charges for the related revenue code.

Activities Permitted - Codes describing the activities permitted by the physician or for which physician's orders are present. 1= Complete Bed rest. 2= Bed rest BRP. 3= Up as Tolerated. 4= Transfer Bed/Chair. 5= Exercises Prescribed. 6= Partial Weight Bearing. 7= Independent at Home. 8= Crutches. 9= Cane. A= Wheelchair. B= Walker. C= No Restrictions. D= Other. A minimum of one must be present for the abbreviated POC.

Admission Date/Start of Care Date - The date the patient was admitted to the provider for inpatient care, outpatient service or start of care. For an admission notice for hospice care enter the effective date of election of hospice benefits.

Admission Hour - The hour during which the patient was admitted for inpatient care.

Admitting Diagnosis - The ICD-9-CM diagnosis code provided at the time of admission as stated by the physician.

Assessment Date - HIPPS Assessment Date.

Assignment of Benefits Certification Indicator - A code showing whether the provider has a signed form authorizing the third party payer to pay the provider. Y=Benefits assigned. N=Benefits not assigned.

Attending Physician Name - Name of the licensed physician who would normally be expected to certify and recertify the medical necessity of the services rendered and/or who has primary responsibility for the patient's medical care and treatment.

Attending Physician Number - Number assigned to identify attending physician. For Medicare this must be the UPIN.

Attending Physician's Zip Code - The nine-digit ZIP code from the address field on the HCFA-485.

Authorization From Date - Beginning date of a period being authorized for a stay extension, admission, or performance of a procedure.

Authorization HCPCS Number - A reference that indicates the HCPCS being authorized by the PRO or payer.

Authorization Number - A number or other code issued to the provider by the payer or the PRO granting permission to the provider for a procedure, admission, or extension of stay.

Authorization Revenue Code - A reference that indicates the RC being authorized by the PRO or payer.

Authorization Thru Date - Ending date of a period being authorized for a stay extension, admission, or performance of a procedure.

Authorization Type - A code that specifies the type of authorization contained in the particular iteration of the authorization for this payer.

Authorization - Any of 4 iterations of the authorization data used to provide detailed information regarding an authorization by a PRO or a payer.

Blood-Deductible Pints - The number of unreplaced pints of whole blood or units of packed red cells furnished for which the patient is responsible. Shown as value code 38.

Blood-Furnished Pints - Total number of pints of whole blood or units of packed red cells furnished to the patient. Shown as value code 37.

Blood-Replaced - The total number of pints of whole blood or units of packed red cells furnished to the patient that are replaced by or on behalf of the patient. Shown as value code 39.

CHAMPUS Insurer Provider Number - The number assigned to the provider by CHAMPUS.

Cert/Recert/Mod - One of the following applicable codes: C= Certification. R= Recertification. M= Modified.

Certificate/Social Security Number/Health Insurance Claim Identification Number - Insured's unique identification number assigned by the payer organization. For Medicare purposes, enter the patient's Medicare HIC number as on the Health Insurance Card, Certificate of Award, Utilization Notice, Temporary Eligibility Notice, Hospital Transfer Form, or as reported by the Social Security Office.

Certification Period - From/To dates of period to be covered by this plan of treatment.

Coinsurance Days - The inpatient Medicare days occurring after the 60th day and before the 91st day in a single spell of illness.

Coinsurance - That amount assumed by the hospital to be applied toward the patient's coinsurance amount involving the indicated payer. Shown as value code 09, 11, A2, B2 or C2.

Condition Codes - Code(s) used to identify condition(s) relating to this bill that may affect payer processing (See Addendum C of UB-92 instructions).

Contract Number - Number Identifying a contracted organization participating in the Medicare Choices Demonstration

Corresponding Data - Narrative data from the plan of treatment.

Country Code - Four position code indicating the geographic location of the submitter or provider.

Covered Days - The number of days covered by the primary payer, as qualified by the payer organization.

Data ID Number - Number corresponding to the data element narrative on plan of treatment.

Data ID - Identifies submittal of HCFA-485 and HCFA-486 data or HCFA-486 data only. 1= HCFA-485 and HCFA-486. 2= HCFA-486 only. Required for abbreviated POC.

Date (Agency) Last Contacted The Physician - Date of agency's most recent physician contact.

Date Physician Last Saw the Patient - Date (if known) that the patient was last seen by the physician.

Date of Onset/Exacerbation of Principal Diagnosis - The date of onset or date of exacerbation of the principal diagnosis.

Date of Surgical Procedure - The date the surgery was performed.

Dates of Onset/Exacerbation - The date of onset or exacerbation of the secondary diagnosis. The related dates are entered in the same order as the secondary diagnosis codes.

Deductible - The amount assumed by the hospital to be applied to the patient's deductible amount involving the indicated payer (A, B and/or C). Shown as value code 06, A1, B1 or C1.

Discharge Date - Date that the patient was discharged from inpatient care.

Discharge Hour - Hour that the patient was discharged from inpatient care (See Addendum C of UB-92 instructions).

Discipline - Code indicating discipline(s) ordered by physician: SN= Skilled Nursing. PT= Physical Therapy. ST= Speech Therapy. OT= Occupational Therapy. MS= Medical Social Worker. AI= Home Health Aide.

Employer Location - The specific location for the employer of the individual covered by this insurance payor.

Employer Name - Name of employer that may provide health care coverage for the individual covered by this insurance payor.

Employment Status Code - A code used to define the employment status of the individual covered by this insurance payor. (See Addendum C of UB-92 instructions.)

Estimated Amount Due - The amount estimated by the hospital to be due from the indicated payer.

Estimated Responsibility - The amount estimated by the hospital to be paid by the indicated payer or patient. Shown as value code A3, B3, C3 or D3.

External Cause of Injury (E-code) - The ICD-9-CM code which describes the external cause of the injury, poisoning or adverse effect. Use of this data element is voluntary in States where E-coding is not required.

Federal Tax Number (EIN) - The number assigned to the provider by the Federal government for tax reports purposes. Also known as a tax identification number (TIN) or employer identification number (EIN).

Federal Tax Sub ID - Four position modifier to Federal Tax ID listed above.

Form Locator - The item number on the UB-92 hardcopy form.

Frequency and Duration - 6 position code indicating the frequency and duration of visits during the period covered by the plan of care. Position 1 is the number of visits. Positions 2-3 are an alpha expression of the period of time. Positions 4-6 are the duration of the plan. Enter the frequency codes in the order being rendered. Position 1 codes = 1-9 Position 2-3 codes = DA, WK, MO, Q_, __ DA= day, WK= week, MO= month, Q_= every n days where n = the number in positions 4-6, __ = PRN (whenever necessary) Position 4-6 = duration in days = 001-999 Examples: 1 visit daily for 10 days = 1DA010. 1 visit every 2 months = 1Q_060. A minimum of one group must be present for the abbreviated POC.

Frequency of Visits - 6 position code indicating the frequency and duration of visits during the period covered by the plan of treatment. Position 1 is the number of visits. Positions 2-3 are an alpha expression of the period of time. Positions 4-6 are the duration of the plan. Enter the frequency codes in the order being rendered. Position 1 codes = 1-9 = n Position 2-3 codes = DA, WK, MO, Q DA= day, WK= week, MO= month, Q= every n days Position 4-6 = duration in days = 001-999 Examples: 1 daily visit for 10 days = 1DA010 2 visits every 9 days for 3 months = 2 Q090 A minimum of one group must be present for the abbreviated POC.

Functional Limitation Code - Codes describing the patient's functional limitations as assessed by the physician. 1= Amputation. 2= Bowel/Bladder (Incontinence). 3= Contracture. 4= Hearing. 5= Paralysis. 6=Endurance. 7= Ambulation. 8= Speech. 9=Legally Blind. A= Dyspnea with Minimal Exertion. B= Other. A minimum of one must be present on abbreviated POC.

HCPCS/Procedure Code - Procedure code reported in record types identify services so that appropriate payment can be made. HCFA Common Procedural Coding System HCPCS code is required for many specific types of outpatient services and a few inpatient services. May include up to two modifiers.

HICN-Health Insurance Claim Identification Number.

Implant Date - For explanted or implanted devices only. Date of implant for the explanted or replaced device.

Inpatient Ancillary Non-Covered Charges - Charges pertaining to the related UB-92 inpatient ancillary revenue center code that the primary payer will not cover.

Inpatient Ancillary Revenue Code - UB-92 revenue center code for the inpatient ancillary services provided. Includes codes 22X through 99X.

Inpatient Ancillary Total Charges - Total charges pertaining to the related UB-92 inpatient ancillary revenue center code.

Inpatient Ancillary Units of Service - A quantitative measure of services rendered by inpatient UB-92 revenue center category to or for the patient which includes such items as number of miles, pints of blood, number of renal dialysis treatments, etc.

Insurance Group Number - The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered.

Insured Address - Insured's current mailing address. Address Line 1. Address Line 2. City. State. Zip.

Insured Group Name - Name of the group or plan that provides insurance to the insured.

Insured's Name - Name of the individual in whose name the insurance is carried. Last Name First Name Middle Initial

Insured's Sex - A code indicating the sex of the insured. M=Male F=Female U=Unknown

Leads Left In Patient - A code to indicate whether former lead was left in patient, explanted, or did not exist.

Lifetime Reserve Days - Under Medicare, each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital services during a spell of illness.

Medicaid Provider Number - The number assigned to the provider by Medicaid.

Medical Record Number - Number assigned to patient by hospital or other provider to assist in retrieval of medical records.

Medicare Covered - The following are applicable codes: Y=Covered. N= Noncovered.

Medicare Provider Number - The number assigned to the provider by Medicare.

Mental Status Code - Codes describing the patient's mental condition. 1= Oriented. 2= Comatose. 3=Forgetful. 4= Depressed. 5= Disoriented. 6=Lethargic. 7= Agitated. 8= Other. A minimum of one must be present for the abbreviated POC.

Model Number - Model number of the device implanted or explanted during the procedure.

Modifier - Two position codes serving as modifier to HCPCS procedure.

Non-Covered Accommodation Charges-Revenue Centers - Sum of accommodation charges not covered by primary payer for this bill.

Non-Covered Days - Days of care not covered by the primary payer.

Number of Grace Days - The number of days determined by the PRO to be necessary to arrange for the patient's post discharge care. Shown as value code 46.

Occurrence Code - A code defining a significant event relating to this bill that may affect payer processing. (See Addendum C of UB-92 instructions.) Occurrence Code and occurrence date repeat for a total 10 iterations.

Occurrence Date - Date associated with the Occurrence Code in the preceding field. (See Addendum C of UB-92 instructions.) Both occurrence code and occurrence date repeat for a total of 10 iterations.

Occurrence Span Code - A code that identifies an event that relates to the payment of the claim. (See Addendum C of UB-92 instructions.) The occurrence span code and both of the associated dates are repeated for a total of 2 iterations.

Occurrence Span Dates - The dates related to the occurrence span code shown in the preceding field.

Operating Physician Name - Name used by the provider to identify the operating physician in the provider records.

Operating Physician Number - Number used by the provider to identify the operating physician in the provider records. For Medicare this must be the UPIN. The UPIN must be left justified in the field.

Ordering Physician Name - Name used by the provider to identify the physician who ordered the procedure in the provider records.

Ordering Physician Number - Number used by the provider to identify the physician who ordered the procedure in the provider records. For Medicare this must be the UPIN.

Other Diagnosis Codes - The ICD-9-CM diagnoses codes corresponding to additional conditions that co-exist at the time of admission, or develop subsequently, and which have an effect on the treatment received or the length of stay.

Other Insurer Provider Number - The number assigned to the provider by an insurer other than Medicare, Medicaid or CHAMPUS.

Other Physician ID Name/Number - The name and/or number of the licensed physician other than the attending physician as defined by the payer organization. For Medicare purposes the number must be the UPIN.

Other Procedure Code - The code identifying the procedure, other than the principal procedure, performed during the billing period covered by this bill.

Other Procedure Date - Date that the procedure indicated by the related code (preceding field) was performed.

Outpatient Date of Service - The date the associated service as identified by the outpatient UB-92 revenue center code was delivered.

Outpatient Non-Covered Charges-Charges pertaining to the related outpatient UB-92 revenue center code that the primary payer will not cover.

Outpatient Revenue Center Cod-UB-92 revenue center code for outpatient ancillary services provided.

Outpatient Total Charges-Total charges for this bill (revenue code= 0001).

Outpatient Units of Service-A quantitative measure of services rendered by outpatient UB-92 revenue center category to or for the patient which includes such items as number of miles, pints of blood, number of renal dialysis treatments, etc.

PRO Approval Indicator-An indicator describing the determination arrived at by the PRO. Shown as condition code C1 - C7.

PRO Approved Stay Dates-The first and last days that were approved when not all of the stay is approved by PRO. Shown as occurrence span code M0.

Patient Address-The address of the patient as qualified by the payer organization. Address Line 1. Address Line 2. City. State (P.O. Code). Zip.

Patient Birthdate-The date of birth of the patient. Include pos. Year.

Patient Control Number-Patient's unique alpha-numeric identification number assigned by the provider to facilitate retrieval of individual case records posting of payment. Use to link multiple records for a single claim.

Patient Marital Status-The marital status of the patient at date of admission, outpatient service, or start of care. (See Addendum C of UB-92 instructions.)

Patient Name-Last name, first name, and middle initial of the patient.

Patient Receiving Care in 1861 (j)(1) Facility-Y= Yes. N= No. D= Do not know

Patient Sex-The sex of the patient as recorded at date of admission, outpatient service, or start of care. M=Male. F=Female. U=Unknown.

Patient Status-A code indicating patient's status as of the statement covers thru date. (See Addendum C of UB-92 instructions.)

Patient's Relationship to Insured-A code indicating the relationship of the patient to the identified insured. (See Addendum C of UB-92 instructions.)

Payer Identification-Number identifying the payer A organization from which the provider might expect some payment for the bill.

Payer Name-Name identifying each payer organization from which the provider might expect some payment for the bill.

Payer Sub-identification- The identification of the specific office within the insurance carrier designated as responsible for this claim.

Payments Received- Amount patient has paid to the provider towards this bill.

Physical Record Count (Excluding Screen)-The total number of physical records submitted for this bill, including all record types 20 through 8n, and excluding record type 90.

Physician Number Qualifying Codes-The type of physician number being submitted. UP = UPIN. FI = Federal Taxpayer ID Number. SL = State License ID Number. SP = Speciality License Number.

Primary Payer Code-Identifies reason another payer is primary to Medicare. (See Addendum C of UB-92 instructions.)

Principal Diagnosis Code-The ICD-9-CM diagnosis code describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for causing this hospitalization).

Principal Procedure Code-The code that identifies the principal procedure performed during the period covered by this bill.

Principal Procedure Date-The date on which the principal procedure described on the bill was performed.

Procedure Coding Method Used- An indicator that identifies the coding method used for procedure coding on the bill. (See Addendum C of UB-92 instructions.)

Processing Date("Date Bill Submitted" on HCFA-1450).-Date submitter prepares file.

Prognosis-Code indicating physician's prognosis for the patient. 1= Poor. 2= Guarded. 3= Fair. 4=Good. 5= Excellent.

Provider Address-Complete mailing address to which the provider wishes payment sent. Street address or box number. City. State (P.O. abbreviations). Zip.

Provider FAX Number-FAX number for provider.

Provider Identification Number-Six digit number assigned by Medicare.

Provider Name-Name of provider submitting this batch of bills.

Provider Telephone Number-Telephone number, including area code, at which the provider wishes to be contacted for claims development.

Receiver Identification- Number identifying to the provider the organization designated to receive this file. (See Addendum C of UB-92 instructions.)

Receiver Sub-Identification-The identification of the specific location within the receiver organization designate to receive the tape or transmission.

Receiver Type Code-A code indicating the class of organization designated to receive this tape or transmission. (See Addendum C of UB-92 instructions.)

Record Identification Code-Identifies all components implanted or explanted in a specific procedure.

Release of Information Certification Indicator-A code indicating whether the provider has on file a signed statement permitting the payer to release data to other organizations in order to adjudicate the claim. (See Addendum C of UB-92 instructions.)

Remarks-Notations relating specific state and local needs providing additional information necessary to adjudicate the claim or otherwise fulfill state reporting requirements. Also used for overflow data for any element for which there is not enough space.

Returned to Manufacturer-Code to indicate if explanted device has been returned to the manufacturer.

SOC Date-Date covered home health services began Required for abbreviated POC.

Sequence Number-Sequential number from 01 to nn assigned to individual records within the same specific record type code to indicate the sequence of the physical record within the record type. Records 21-2n don't have a sequence number greater than 01. Records 01, 10, 90, 91, 95 and 99 do not have sequence numbers. The sequence number for record types 30, 31, 34, and 80 are used as matching criteria to determine which type 30, type 31, type 34, and/or type 80 records are associated.

Serial Number- Number that uniquely identifies the specific device

Source of Admission-A code indicating the source of this admission. (See Addendum C of UB-92 instructions.)

Source of Payment Code-A code indicating source of payment associated with this payer record. (See Addendum C of UB-92 instructions.)

Special Program Indicator-A code indicating that the services included on this bill are related to a special program. Shown as condition codes A0-A9. (See Addendum C of UB-92 instructions).

State Code- Code that indicates the state coding structure to which the form locators apply.

Statement Covers Period-The beginning and ending service dates of the period covered by this bill.

Submitter Address-Mailing address of the submitter of this file. Address. City. State. Zip.

Submitter EIN-Federally assigned Employer Identification Number (EIN) of file submitter. EIN is also referred to as the Tax Identification Number (TIN).

Submitter FAX Number-FAX number for the submitter

Submitter Name-Name of provider, third party billing service, or other organization to which the receiver/processor must direct inquiries regarding this transmittal.

Submitter Telephone Number-Telephone number, including area code, at which the submitter wishes to be contacted for claim development.

Surgical Procedure Code-The ICD-9-CM code describing the surgical procedure (if any) most relevant to the care being rendered.

Total Accommodations Charges Revenue Center-Total accommodation charges for this bill.

Total Ancillary Charges-Revenue Centers-Total ancillary charges for this bill.

Total Visits Projected This Cert.-Total covered visits to be rendered by each discipline during the period covered by the plan of treatment. Include PRN visits. Required for abbreviated POC.

Treatment Authorization Code-A number or other indicator that designates that the treatment covered by this bill has been authorized by the PRO or by the payer. Three iterations, one each for Payer A, B and/or C.

Treatment Codes-Codes describing the treatment ordered by the physician. Show in ascending order. Valid codes are: A01-A30= Skilled Nursing. B01-B15=Physical Therapy. C01-C09= Speech Therapy. D01-D11= Occupational Therapy. E01-E06= Medical School Services. F01-F15= Home Health Aide. One or more codes must be present for each discipline (e.g. SN, PT, etc.). Required for abbreviated POC.

Type Of Facility-Coding indicating type of facility from which the patient was most recently discharged. A=Acute. S= SNF. I= ICF. R= Rehabilitation Facility. O= Other.

Type of Admission-A code indicating the priority of this admission. (See Addendum C of UB-92 instructions.)

Type of Batch-A code indicating the types of bills that occur in this batch. (See Addendum C of UB-92 instructions.)

Type of Bill-A code indicating the specific type of bill (hospital inpatient, SNF outpatient, adjustments, voids, etc.). (See Addendum C of UB-92 instructions.)

Value Amount-Amount of money related to the associated value code. (See Addendum C of UB-92 instruction for Value codes.)

Value Code-A code that identifies data of a monetary nature that is necessary for processing this claim as required by the payer organization. (See Addendum C of UB-92 instructions.)

Verbal Start of Care Date-The date the agency received the verbal orders from the physician, if this is prior to the date care started.

Version Code-A code that indicates the version of the National Specifications submitted on this file, disk, etc. 001 = UB-82 data set as finally approved 08/17/82. 003 = UB-82 data set as revised to handle $1,000,000 charges, bigger fields for units and UPINs. Effective 01/01/92 and 04/01/92. 004 = UB-92 data set as approved by NUBC 2/92. Effective 10/01/93.

Visits(This Bill) Rel.to Prior Certification-Total visits on this bill rendered prior recertification "to" date. If applicable, required for abbreviated POC.

Warranty Expiration Date-Expiration date of the warranty on a specified device.

State Postal Abbreviation Codes

Alabama	AL	New Hampshire	NH
Alaska	AK	New Jersey	NJ
Arizona	AZ	New Mexico	NM
Arkansas	AR	New York	NY
California	CA	North Carolina	NC
Colorado	CO	North Dakota	ND
Connecticut	CT	Ohio	OH
Delaware	DE	Oklahoma	OK
District of Columbia	DC	Oregon	OR
Florida	FL	Pennsylvania	PA
Georgia	GA	Rhode Island	RI
Hawaii	HI	South Carolina	SC
Idaho	ID	South Dakota	SD
Illinois	IL	Tennessee	TN
Indiana	IN	Texas	TX
Iowa	IA	Utah	UT
Kansas	KS	Vermont	VT
Kentucky	KY	Virginia	VA
Louisiana	LA	Washington	WA
Maine	ME	West Virginia	WV
Maryland	MD	Wisconsin	WI
Massachusetts	MA	Wyoming	WY
Michigan	MI	Canal Zone	CZ
Minnesota	MN	Guam	GU
Mississippi	MS	Puerto Rico	PR
Missouri	MO	Virgin Islands	VI
Montana	MT	Canada	CN
Nebraska	NE	Mexico	MX
Nevada	NV	All Other	FC

01-01	Record type	NA
01-02	Submitter EIN	1 020 NM109 ISA06
01-03	Multiple Provider Billing File Indicator	NA
01-04	Filler (National Use)	NA
01-05	Receiver Type Code	NA
01-06	Receiver Identification	0 020 GS03 ISA08
01-07	Receiver Sub-Identification	0 020 GS03 ISA08
01-08	Filler	NA
01-09	Submitter Name	1 020 NM103
01-10	Submitter Address	1 030 N301
01-11	Submitter City	1 035 N401
01-12	Submitter State	1 035 N402
01-13	Submitter ZIP Code	1 035 N403
01-14	Submitter FAX Number	1 045 PER06
01-15	Submitter Country Code	1 035 N404
01-16	Submitter Telephone Number	1 045 PER04
01-17	File Sequence & Serial Number	1 010 BGN02
01-18	Test/Production Indicator	ISA15
01-19	Date of Receipt (CCYYMMDD)	GS04
01-20	Processing Date ("Date Bill Submitted" on HCFA-1450)	1 010 BGN03
01-21	Filler	NA
01-22	Version Code	NA

10-01	Record type	NA
10-02	Type of Batch	2 130 CLM05-01 CLM05-03
10-03	Batch Number	NA
10-04	Federal Tax Number or EIN	2 015 NM109
10-05	Federal Tax Sub ID	2 015 NM109
10-06	National Provider Number	2 005 PRV03
10-07	Medicaid Provider Number	NA
10-08	CHAMPUS Insurer Provider Number	NA
10-09	Other Insurer Provider Number	NA
10-10	Other Insurer Provider Number	NA
10-11	Provider Telephone Number	2 040 PER04
10-12	Provider Name	2 015 NM103
10-13	Provider Address	2 025 N301
10-14	Provider City	2 030 N401
10-15	Provider State	2 030 N402
10-16	Provider ZIP Code	2 030 N403
10-17	Provider FAX Number	2 040 PER06
10-18	Provider Country Code	2 030 N404
10-19	Filler (National Use)	NA
10-20	Filler (State Use)	NA

20-01	Record type	NA
20-02	Filler (National Use)	NA
20-03	Patient Control Number	2 130 CLM01
20-04	Patient Last Name	2 095 NM103
20-05	Patient First Name	2 095 NM104

20-06	Patient Middle Initial	2 095 NM105
20-07	Patient Sex	2 115 DMG03
20-08	Patient Birthdate (CCYYMMDD)	2 115 DMG02
20-09	Patient Marital Status	2 115 DMG04
20-10	Type of Admission	2 140 CL101
20-11	Source of Admission	2 140 CL102
20-12	Patient Address - Line 1	2 105 N301
20-13	Patient Address - Line 2	2105 N302
20-14	Patient City	2 110 N401
20-15	Patient State	2 110 N402
20-16	Patient ZIP Code	2 110 N403
20-17	Admission/Start of Care Date (CCYYMMDD)	2 135.B DTP03
20-18	Admission Hour	2 135.B DTP03
20-19	Statement Covers From (CCYYMMDD)	2 135.A DTP03
20-20	Statement Covers Thru (CCYYMMDD)	2 135.A DTP03
20-21	Patient Status	2 140 CL103
20-22	Discharge Hour	2 135.C DTP03
20-23	Payments Received (Patient line)	2 175.A AMT02
20-24	Estimated Amount Due (Patient line)	2 175.B AMT02
20-25	Medical Record Number	1 125 REF02
20-26	Filler (National Use)	NA

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21-01	Record type	NA
21-02	Sequence Number	NA
21-03	Patient Control Number	2 130 CLM01
21-04	Employer Name	2 325.D NM103
21-05	Employer Address	2 335.D N301
21-06	Employer City	2 340.D N401
21-07	Employer State	2 340.D N402
21-08	Employer ZIP Code	2 340.D N403
21-09	Employment Status Code	2 355.D REF02
21-09a	Employer Qualifier	NA
21-10	Filler (National Use)	NA
21-11	Employer Name	2 325.D NM103
21-12	Employer Address	2 335.D N301
21-13	Employer City	2 340.D N401
21-14	Employer State	2 340.D N402
21-15	Employer ZIP Code	2 340.D N403
21-16	Employment Status Code	2 355.D REF02
21-16a	Employer Qualifier	NA
21-17	Filler (National Use)	NA

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22-01	Record type	NA
22-02	Sequence Number	NA
22-03	Patient Control Number	2 130 CLM01
22-04	State Code	NA
22-05	Form Locator 2 (upper line)	NA
22-06	Form Locator 2 (lower line)	NA
22-07	Form Locator 11 (upper line)	NA
22-08	Form Locator 11 (lower line)	NA

22-09	Form Locator 56 (upper line)	NA
22-10	Form Locator 56 (2nd line)	NA
22-11	Form Locator 56 (3rd line)	NA
22-12	Form Locator 56 (4th line)	NA
22-13	Form Locator 56 (patient line)	NA
22-14	Form Locator 78 (upper line)	NA
22-15	Form Locator 78 (lower line)	NA
22-16	Filler (Local Use)	NA
30-01	Record type	NA
30-02	Sequence Number	2 045 SBR01
30-02	Sequence Number	2 285 SBR01
30-03	Patient Control Number	2 130 CLM01
30-04	Source of Payment Code	2 130 CLM03
30-04	Source of Payment Code	2 310 OI01
30-05	Payer Identification	2 325.A NM109
30-06	Payer Sub-Identification	2 325.A NM109
30-07	Certificate/SocSecNumber/Health Insurance Claim/ID.	2 095 NM109
		2 325.B NM109
30-08a	Payer Identification Indicator	2 325.A NM108
30-08b	Payer Name	2 325.A NM103
30-09	Primary Payer Code	2 045 SBR09
		2 285 SBR09
30-10	Insurance Group Number	2 285 SBR03
30-11	Insured Group Name	2 285 SBR04
30-12	Insured's Last Name	2 325.B NM103
30-13	Insured's First Name	2 325.B NM104
30-14	Insured's Middle Initial	2 325.B NM105
30-15	Insured's Sex	2 115 DMG03
		2 305 DMG03
30-16	Release of Information Certification Indicator	2 130 CLM09
		2 310 OI06
30-17	Assignment of Benefits Certification Indicator	2 130 CLM08
		2 310 OI03
30-18	Patient's Relationship to Insured	2 090 PAT01
		2 285 SBR02
30-19	Employment Status Code	2 090 PAT03
		2 285 SBR08
30-20	Covered Days	2 240.A QTY02
30-21	Noncovered Days	2 240.B QTY02
30-22	Coinsurance Days	2 240.C QTY02
30-23	Lifetime Reserve Days	2 240.D QTY02
30-24	Provider Identification Number	2 005 PRV03
		2 355.AB REF02
30-25	Payments Received	2 300.A AMT02
30-26	Estimated Amount Due	2 300.B AMT02
31-01	Record type	NA
31-02	Sequence Number	NA

31-03	Patient Control Number	2 130 CLM01
31-04	Insured's Address - Line 1	2 335.B N301
31-05	Insured's Address - Line 2	2 335.B N302
31-05a	Filler	NA
31-06	Insured's City	2 340.B N401
31-07	Insured's State	2 340.B N402
31-08	Insured's ZIP Code	2 340.B N403
31-09	Employer Name	2 325.C NM103
31-10	Employer Address	2 335.C N301
31-11	Employer City	2 340.C N401
31-12	Employer State	2 340.C N402
31-13	Employer ZIP Code	2 340.C N403
31-14	Form Locator 37 (ICN/DCN)	2 355.AC REF02
		2 180.A REF02
31-15	Contract Number	2 325.E NM109
31-16	Filler (National Use)	NA

32-01	Record type '32'	NA
32-02	Sequence Number	NA
32-03	Patient Control Number	NA
32-04	Payer Name	NA
32-05	Payer Address	NA
32-06	Payer Address	NA
32-07	Payer City	NA
32-08	Payer State	NA
32-09	Payer Zip Code	NA
32-10	Filler (National Use)	NA

34-01	Record type	NA
34-02	Sequence Number	NA
34-03	Patient Control Number	NA
34-04	Authorization Type 1	NA
34-05	Authorization Number	180.AA REF02
34-06	Authorization From Date (CCYYMMDD)	NA
34-07	Authorization Thru Date	NA
34-08	Authorization Revenue Code	NA
34-09	Authorization HCPCS Procedure Code	NA
34-10	Authorization - 2	180.AA REF02
34-11	Authorization - 3	180.AA REF02
34-12	Filler (National Use)	NA

40-01	Record Type	NA
40-02	Sequence Number	NA
40-03	Patient Control Number	2 130 CLM01
40-04	Type of Bill	2 130 CLM05-01 CLM05-03
40-05	Treatment Authorization Code-A	2 355.AA REF02
40-06	Treatment Authorization Code-B	2 355.AA REF02
40-07	Treatment Authorization Code-C	2 355.AA REF02

40-08	Occurrence Code - 1	2 225.C HI01-02
40-09	Occurrence Date - 1 (CCYYMMDD)	2 225.C HI01-04
40-10	Occurrence Code - 2	2 225.C HI02-02
40-11	Occurrence Date - 2 (CCYYMMDD)	2 225.C HI02-04
40-12	Occurrence Code - 3	2 225.C HI03-02
40-13	Occurrence Date - 3 (CCYYMMDD)	2 225.C HI03-04
40-14	Occurrence Code - 4	2 225.C HI04-02
40-15	Occurrence Date - 4 (CCYYMMDD)	2 225.C HI04-04
40-16	Occurrence Code - 5	2 225.C HI05-02
40-17	Occurrence Date - 5 (CCYYMMDD)	2 225.C HI05-04
40-18	Occurrence Code - 6	2 225.C HI06-02
40-19	Occurrence Date - 6 (CCYYMMDD)	2 225.C HI06-04
40-20	Occurrence Code - 7	2 225.C HI07-02
40-21	Occurrence Date - 7 (CCYYMMDD)	2 225.C HI07-04
40-22	Occurrence Span Code - 1	2 225.D HI01-02
40-23	Occurrence Span FROM DATE - 1 (CCYYMMDD)	2 225.D HI01-04
40-24	Occurrence Span THRU DATE - 1 (CCYYMMDD)	2 225.D HI01-04
40-25	Occurrence Span Code - 2	2 225.D HI02-02
40-26	Occurrence Span FROM DATE - 2 (CCYYMMDD)	2 225.D HI02-04
40-27	Occurrence Span THRU DATE - 2	2 225.D HI02-04
40-28	Filler (National Use)	NA

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41-01	Record Type	NA
41-02	Sequence Number	NA
41-03	Patient Control Number	2 130 CLM01
41-04	Condition Code - 1	2 225.E HI01-02
41-05	Condition Code - 2	2 225.E HI02-02
41-06	Condition Code - 3	2 225.E HI03-02
41-07	Condition Code - 4	2 225.E HI04-02
41-08	Condition Code - 5	2 225.E HI05-02
41-09	Condition Code - 6	2 225.E HI06-02
41-10	Condition Code - 7	2 225.E HI07-02
41-11	Condition Code - 8	2 225.E HI08-02
41-12	Condition Code - 9	2 225.E HI09-02
41-13	Condition Code - 10	2 225.E HI10-02
41-14	Form Locator 31 (upper)	NA
41-15	Form Locator 31 (lower)	NA
41-16	Value Code - 1	2 225.F HI01-02
41-17	Value Amount - 1	2 225.F HI01-04
41-18	Value Code - 2	2 225.F HI02-02
41-19	Value Amount - 2	2 225.F HI02-04
41-20	Value Code - 3	2 225.F HI03-02
41-21	Value Amount - 3	2 225.F HI03-04
41-22	Value Code - 4	2 225.F HI04-02
41-23	Value Amount - 4	2 225.F HI04-04
41-24	Value Code - 5	2 235.F HI05-02
41-25	Value Amount - 5	2 225.F HI05-04
41-26	Value Code - 6	2 225.F HI06-02
41-27	Value Amount - 6	2 225.F HI06-04
41-26	Value Code - 7	2 225.F HI07-02
41-28	Value Amount - 7	2 225.F HI07-04
41-30	Value Code - 8	2 225.F HI08-02
41-31	Value Amount - 8	2 225.F HI08-04
41-32	Value Code - 9	2 225.F HI09-02
41-33	Value Amount - 9	2 225.F HI09-04

41-34	Value Code - 10	2 225.F HI10-02
41-35	Value Amount - 10	2 225.F HI10-04
41-36	Value Code - 11	2 225.F HI11-02
41-37	Value Amount - 11	2 225.F HI11-04
41-38	Value Code - 12	2 225.F HI12-02
41-39	Value Amount - 12	2 225.F HI12-04
41-40	Filler (National Use)	NA

50-01	Record type	NA
50-02	Sequence Number	NA
50-03	Patient Control Number	2 130 CLM01
50-04	Accommodations Revenue Code	2 395 SV201
50-05	Accommodations Rate	2 395 SV206
50-06	Accommodations Days	2 395 SV205
50-07	Accommodations Total Charges	2 395 SV203
50-08	Accommodations Noncovered Charges	2 395 SV207
50-09	Form Locator 49	NA
50-10	Filler (National Use)	NA
50-11	Accommodations - 2	2 395 SV201
50-12	Accommodations - 3	2 395 SV201
50-13	Accommodations - 4	2 395 SV201

60-01	Record type	NA
60-02	Sequence Number	NA
60-03	Patient Control Number	2 130 CLM01
60-04	Inpatient Ancillary Revenue Code	2 395 SV201
60-05	HCPCS Procedure Code/HIPPS code	2 395 SV202-02
60-06	Modifier 1 (HCPCS & CPT-4)	2 395 SV202-03
60-07	Modifier 2 (HCPCS & CPT-4)	2 395 SV202-04
60-08	Inpatient Ancillary Units of Service	2 395 SV205
60-09	Inpatient Ancillary Total Charges	2 395 SV203
60-10	Inpatient Ancillary Noncovered Charges	2 395 SV207
60-11	Form Locator 49	NA
60-12	HIPPS Assessment Date (CCYYMMDD)	2 475 DTP03
60-12a	Filler (National Use)	NA
60-13	Inpatient Ancillaries - 2	2 395 SV201
60-14	Inpatient Ancillaries - 3	2 395 SV201

61-01	Record type	NA
61-02	Sequence Number	NA
61-03	Patient Control Number	2 130 CLM01
61-04	Revenue Center Code	2 395 SV201
61-05	HCPCS Procedure Code	2 395 SV202-02
61-06	Modifier 1 (HCPCS & CPT-4)	2 395 SV202-03
61-07	Modifier 2 (HCPCS & CPT-4)	2 395 SV202-04
61-08	Units of Service	2 395 SV205
61-09	Form Locator 49	NA
61-10	Outpatient Total Charges	2 395 SV203
61-11	Outpatient Noncovered Charges	2 395 SV207
61-12	Date of Service (CCYYMMDD)	2 475 DYTP03
61-13	Filler (National Use)	NA

61-14	Revenue Code - 2	2 395 SV201
61-15	Revenue Code - 3	2 395 SV201
70-01	Record Type	NA
70-02	Sequence “01"	NA
70-03	Patient Control Number	2 130 CLM01
70-04	Principal Diagnosis Code	2 225.A HI02-02
70-05	Other Diagnosis Code - 1	2 225.A HI03-02
70-06	Other Diagnosis Code - 2	2 225.A HI04-02
70-07	Other Diagnosis Code - 3	2 225.A HI05-02
70-08	Other Diagnosis Code - 4	2 225.A HI06-02
70-09	Other Diagnosis Code - 5	2 225.A HI07-02
70-10	Other Diagnosis Code - 6	2 225.A HI08-02
70-11	Other Diagnosis Code - 7	2 225.A HI09-02
70-12	Other Diagnosis Code - 8	2 225.A HI10-02
70-13	Principal Procedure Code	2 225.B HI01-02
70-14	Principal Procedure Date	2 225.B HI01-04
70-15	Other Procedure Code - 1	2 225.B HI02-02
70-16	Other Procedure Date - 1 (CCYYMMDD)	2 225.B HI02-04
70-17	Other Procedure Code - 2	2 225.B HI03-02
70-18	Other Procedure Date - 2 (CCYYMMDD)	2 225.B HI03-04
70-19	Other Procedure Code - 3	2 225.B HI04-02
70-20	Other Procedure Date - 3 (CCYYMMDD)	2 225.B HI04-04
70-21	Other Procedure Code - 4	2 225.B HI05-02
70-22	Other Procedure Date - 4 (CCYYMMDD)	2 225.B HI05-04
70-23	Other Procedure Code - 5	2 225.B HI06-02
70-24	Other Procedure Date - 5 (CCYYMMDD)	2 225.B HI06-04
70-25	Admitting Diagnosis Code	2 225.A HI01-02
70-26	External Cause of Injury (E-Code)	2 225.A HI11-02
70-27	Procedure Coding Method Used	2 225.B HI01-01
70-28	Filler (National Use)	NA
70-01	Record Type	NA
70-02	Sequence	NA
70-03	Patient Control Number	2 130 CLM01
70-04	Form Locator 57	NA
70-05	Filler (National Use)	NA
71-01	Record Type	NA
71-02	Sequence	NA
71-03	Patient Control Number	2 130 CLM01
71-04	Data ID	2 180.B REF02
71-05	SOC Date (CCYYMMDD)	1 135.D DTP03
71-06	Certification Period From (CCYYMMDD)	2 216 CR604
71-07	Certification Period To (CCYYMMDD)	2 216 CR604
71-08	Date of Onset or Exacerbation of Principal Diagnosis	1 135.E DTP03
71-09	Surgical Procedure Code	2 216 CR611
71-10	Date Surgical Procedure Performed	1 135.F DTP03
71-11	Date Secondary Diagnosis-1 (CCYYMMDD)	1 135.I DTP03
71-12	Date Secondary Diagnosis-2 (CCYYMMDD)	1 135.J DTP03
71-13	Functional Limitation Code	2 220.A CRC03 thru CRC07
71-14	Activities Permitted Code	2 220.B CRC03 thru CRC07
71-15	Mental Status Code	2 220.C CRC03 thru CRC07
71-16	Prognosis	2 216 CR601
71-17	Verbal SOC Date (CCYYMMDD)	1 135.H DTP03
71-18	Physician's Last Name	2 250.A NM103

71-19	Physician's First Name		2 250.A NM104
71-20	Physician's Initial		2 250.A NM105
71-21	Physician's ZIP Code		2 270.A N403
71-22	Medicare Covered		2 216 CR607
71-23	Date Physician Last Saw Patient (CCYYMMDD)		1 135.G DTP03
71-24	Date Last Contacted Physician (CCYYMMDD)		1 135.K DTP03
71-25	Patient Receiving Care in 1861(J)(1) Facility		2 216 CR606
71-26	Cert/Recert/Mod		2 216 CR608
71-27	Admission (CCYYMMDD)		2 216 CR616
71-28	Discharge (CCYYMMDD)		2 216 CR616
71-29	Type of Facility		2 216 CR617
72-01	Record Type		NA
72-02	Sequence Number		NA
72-03	Patient Control Number		2 130 CLM01
72-04	Discipline		2 243 CR701
72-05	Visits (This Bill) Related to Prior Certification		2 243 CR702
72-06	Frequency and Duration of Visits - 1		2 244 HSD02, HSD03, HSD06
72-07	Frequency and Duration of Visits - 2		2 244 HSD02, HSD03, HSD06
72-08	Frequency and Duration of Visits - 3		2 244 HSD02, HSD03, HSD06
72-09	Frequency and Duration of Visits - 4		2 244 HSD02, HSD03, HSD06
72-10	Frequency and Duration of Visits - 5		2 244 HSD02, HSD03, HSD06
72-11	Frequency and Duration of Visits - 6		2 244 HSD02, HSD03, HSD06
72-12	Frequency and Duration of Visits - 7		2 244 HSD02, HSD03, HSD06
72-13	Frequency and Duration of Visits - 8		2 244 HSD02, HSD03, HSD06
72-14	Frequency and Duration of Visits - 9		2 244 HSD02, HSD03, HSD06
72-15	Frequency and Duration of Visits -10		2 244 HSD02, HSD03, HSD06
72-16	Frequency and Duration of Visits -11		2 244 HSD02, HSD03, HSD06
72-17	Frequency and Duration of Visits -12		2 244 HSD02, HSD03, HSD06
72-18	Treatment Code - 1		2 225.G HI01-02
72-19	Treatment Code - 2		2 225.G HI02-02
72-20	Treatment Code - 3		2 225.G HI03-02
72-21	Treatment Code - 4		2 225.G HI04-02
72-22	Treatment Code - 5		2 225.G HI05-02
72-23	Treatment Code - 6		2 225.G HI06-02
72-24	Treatment Code - 7		2 225.G HI07-02
72-25	Treatment Code - 8		2 225.G HI08-02
72-26	Treatment Code - 9		2 225.G HI09-02
72-27	Treatment Code -10		2 225.G HI10-02
72-28	Treatment Code -11		2 225.G HI11-02
72-29	Treatment Code -12		2 225.G HI12-02
72-30	Treatment Code -13	Start 2nd occurrence	2 225.G HI01-02
72-31	Treatment Code -14		2 225.G HI02-02
72-32	Treatment Code -15		2 225.G HI03-02
72-33	Treatment Code -16		2 225.G HI04-02
72-34	Treatment Code -17		2 225.G HI05-02
72-35	Treatment Code -18		2 225.G HI06-02
72-36	Treatment Code -19		2 225.G HI07-02
72-37	Treatment Code -20		2 225.G HI08-02
72-38	Treatment Code -21		2 225.G HI09-02
72-39	Treatment Code -22		2 225.G HI10-02

72-40	Treatment Code -23	2 225.G HI11-02
72-41	Treatment Code -24	2 225.G HI12-02
72-42	Treatment Code -25 Start 3rd occurrence	2 225.G HI01-02
72-43	Total Visits Projected This Cert.	2 243 CR703
72-44	Filler (National Use)	NA
72-45	Filler (Local Use)	NA

73-01	Record Type	NA
73-02	Sequence Number	NA
73-03	Patient Control Number	2 130 CLM01
73-04	Filler (National Use)	NA
73-05	Data ID Number	2 190.B NTE01
73-06	Corresponding Data	2 190.B NTE02

74-01	Record Type	NA
74-02	Filler (National Use)	NA
74-03	Patient Control Number	NA
74-04	Attachment Submission Status	NA
74-05	HICN	NA
74-06	Medical Record Number	NA
74-07	Patient Last Name	NA
74-08	Patient First Name	NA
74-09	Patient Middle Initial	NA
74-10	Patient Birthdate (CCYYMMDD)	NA
74-11	Patient Sex	NA
74-12	Principal Diagnosis Code	NA
74-13	Other Diagnosis Code-1	NA
74-14	Other Diagnosis Code-2	NA
74-15	Other Diagnosis Code-3	NA
74-16	Other Diagnosis Code-4	NA
74-17	Start of Care (SOC) Date (CCYYMMDD)	NA
74-18	FROM Date (CCYYMMDD)	NA
74-19	TO Date (CCYYMMDD)	NA
74-20	Provider Number	NA
74-21	Internal Control (ICN/DCN)	NA
74-22	Filler (National Use)	NA

75-01	Record Type '75'	NA
75-02	Sequence Number	NA
75-03	Patient Control Number	NA
	Reasons for Ambulance	NA
	Transportation (occurs 3 times)	NA
75-04	Reason 1 X(3)	NA
75-05	Reason 2 X(3)	NA
75-06	Reason 3 X(3)	NA
75-07	Number of Trips	NA
	Pickup - Destination Code (occurs 2 times)	NA
75-08	Code-1 X(3)	NA
75-09	Code-2 X(3)	NA

75-10	Base Charge		NA
75-11	Number of Miles		NA
75-12	Cost Per Mile		NA
	Ancillary Charges		NA
75-13	Medical Surgical Supplies		NA
75-14	IV Solutions		NA
75-15	Oxygen/Oxygen Supplies		NA
75-16	Injectable Drugs		NA
	Pickup Address		NA
75-17	Place		NA
75-18	City		NA
75-19	State		NA
75-20	Zip Code	NA	
	Destination Address		NA
75-21	Name		NA
75-22	Place		NA
75-23	City		NA
75-24	State		NA
75-25	Zip Code		NA
75-26	Filler		NA

RT 75, Sequence

75-01	Record Type 75		NA
75-02	Sequence Number		NA
75-03	Patient Control Number		NA
75-04	Reason for Transfer		NA
75-05	Reason for Bypass	NA	
	Nearest Facility		NA
75-06	Air Ambulance Justification	NA	
75-07	Ancillary Charge Other		NA
75-08	Remarks		NA

==========

76-01	Record Type ‘76'	NA
76-02	Sequence No.	NA
76-03	Patient Control No.	NA
76-04	Record Format Type-L, Non-routine and Separately Billable Laboratory Tests (Occurs 1 to 4 times)	NA
76-05	HCPCS Code	NA
76-06	Modifier 1	NA
76-07	Modifier 2	NA
76-08	Previous Lab Value	NA
76-09	Date Previous Lab (CCYYMMDD)	NA
76-10	Current Lab Value	NA
76-11	Date Current Lab (CCYYMMDD)	NA
76-12	Lab Tests-Occurrence 2	NA
76-13	Lab Tests-Occurrence 3	NA
76-14	Lab Tests-Occurrence 4	NA
76-15	Filler (National Use)	NA

==========

76-01 Record Type ‘76'

76-02	Sequence No.		NA
76-03	Patient Control Number		NA
76-04	Record Format Type-M Medication Administration (occurs 1 to 3 times)	NA	
76-05	National Drug Code		NA
76-06	Drug Units		NA
76-07	Place of Administration		NA
76-08	Route to Administration		NA
76-09	Frequency and Duration		NA
76-10	Medication-Occurrence 2		NA
76-11	Medication-Occurrence 3 Extra Dialysis Sessions (occurs 1 to 3 times)		NA
76-12	Date of Extra Session (CCYYMMDD)		NA
76-13	Justification for Extra Session		NA
76-14	Extra Dialysis-Occurrence 2		NA
76-15	Extra Dialysis-Occurrence 3 Other Services (occurs 1 to 3 times)	NA	
76-16	HCPCS/CPT Code		NA
76-17	Date Previous Test/Service (CCYYMMDD)		NA
76-18	Date Current Test/Service (CCYYMMDD)		NA
76-19	Other Services-Occurrence 2		NA
76-20	Other Services-Occurrence 3		NA
76-21	Weight in Kg		NA
76-22	Filler (National Use)		NA
77-01	Record type ‘77'		NA
77-02	Sequence number		NA
77-03	Patient Control Number (PCN)		NA
77-04	Record Format - A		NA
77-05	Discipline Physician Information (Fields 6-9)	NA	
77-06	Attending Physician Identifier		NA
77-07	Physician Referral Date (CCYYMMDD)		NA
77-08	Physician Signature Date on Plan of Treatment (CCYYMMDD)	NA	
	Rehabilitation Professional Information (Fields 9-14)		NA
77-09	Rehabilitation Professional Identifier	NA	
77-10	Rehabilitation Professional Name (Last)		NA
77-11	Rehabilitation Professional Name (First)		NA
77-12	Rehabilitation Professional Name (MI)		NA
77-13	Professional Designation of Rehabilitation Professional	NA	
77-14	Rehabilitation Professional Signature Date on Plan of Treatment (CCYYMMDD)	NA	
	Prior Hospitalization Dates (From-Through)(Fields 15-19)		NA
77-15	From Date (CCYYMMDD)	NA	
77-16	Through Date (CCYYMMDD)		NA
77-17	Date of Onset/Exacerbation of Principal Diagnosis (CCYYMMDD)		NA
77-18	Admission Date/Start Care Date (CCYYMMDD)		NA
77-19	Total Visits From Start of Care		NA
77-20	Most Recent Event Requiring Cardiac Rehab Date (CCYYMMDD)		NA
77-21	Treatment Diagnosis Code (ICD-9)		NA
77-22	Treatment Diagnosis (Narrative)		NA
77-23	Filler (National Use)		NA

77-01	Record Type ‘77'	NA
77-02	Sequence Number	NA
77-03	Patient Control Number (PCN)	NA
77-04	Record Format - R	NA
77-05	Discipline Plan of Treatment (POT)(Fields 6-12)	NA
77-06	POT - Status (Initial/Update)	NA
77-07	POT - Date Established (CCYYMMDD)	NA
	POT - Period Covered (From-Through)	NA
77-08	From Date (CCYYMMDD)	NA
77-09	Through Date (CCYYMMDD)	NA
77-10	Frequency and Duration	NA
	Frequency Number	NA
	Frequency Period	NA
	Duration	NA
77-11	Estimated Date of Completion of Outpatient Rehab (CCYYMMDD)	NA
77-12	Service Status (Continue/Discontinue)	NA
77-13	Certification Status	NA
77-14	Date of Last Certification (CCYYMMDD)	NA
77-15	Route of Administration - IM	NA
77-16	Route of Administration - IV	NA
77-17	Route of Administration - PO	NA
77-18	Drug Administered (Narrative)	NA
77-19	Prognosis	NA
77-20	Filler (National Use)	NA

77-01	Record type ‘77'	NA
77-02	Sequence number	NA
77-03	Patient Control Number	NA
77-04	Record Format - N	NA
77-05	Discipline	NA
77-06	Narrative Type Indicator	NA
77-07	Free Form Narrative	NA
77-08	Filler (National Use)	NA

80-01	Record Type	NA
80-02	Sequence	NA
80-03	Patient Control Number	2 130 CLM01
80-04	Physician Number Qualifying Codes	2 250.A NM108, 2 250.B NM108, 2 250.C NM108
80-05	Attending Physician Number	2 250.A NM109
80-06	Operating Physician Number	2 250.B NM109
80-07	Other Physician Number	2 250.C NM109
80-08	Other Physician Number	2 250.C NM109
80-09	Attending Physician Last Name	2 250.A NM103
80-09	Attending Physician First Name	2 250.A NM104
80-09	Attending Physician Middle Initial	2 250.A NM105
80-10	Operating Physician Last Name	2 250.B NM103
80-10	Operating Physician First Name	2 250.B NM104
80-10	Operating Physician Middle Initial	2 250.B NM105
80-11	Other Physician Last Name	2 250.C NM103
80-11	Other Physician First Name	2 250.C NM104

80-11	Other Physician Middle Initial	2 250.C NM105
80-12	Other Physician Last Name	2 250.C NM103
80-12	Other Physician First Name	2 250.C NM104
80-12	Other Physician Middle Initial	2 250.C NM105
80-13	Filler (National Use)	NA

==========

90-01	Record Type	NA
90-02	Filler (National Use)	NA
90-03	Patient Control Number	2 130 CLM01
90-04	Physical Record Count	NA
90-05	Record Type 2n Count	NA
90-06	Record Type 3n Count	NA
90-07	Record Type 4n Count	NA
90-08	Record Type 5n Count	NA
90-09	Record Type 6n Count	NA
90-10	Record Type 7n Count	NA
90-11	Record Type 8n Count	NA
90-12	Record Type 91 Qualifier	NA
90-13	Total Accommodation Charges - Revenue Centers	2 130 CLM02
90-14	Noncovered Accommodation Charges - Revenue Centers	NA
90-15	Total Ancillary Charges - Revenue Centers	2 130 CLM02
90-16	Noncovered Ancillary Charges - Revenue Centers	NA
90-17	Remarks	2 190.A NTE02

==========

91-01	Record Type	NA
91-02	Filler (National Use)	NA
91-03	Patient Control Number	2 130 CLM01
91-04	Remarks (Additional)	2 190.A NTE02
91-05	Filler (National Use)	NA

==========

95-01	Record Type	NA
95-02	Federal Tax Number (EIN)	1 020 NM109
95-03	Receiver Identification	NA
95-04	Receiver Sub-Identification	NA
95-05	Type of Batch	2 130 CLM05-01, CLM05-03
95-06	Number of Claims	NA
95-07	Number of 3M Batch Attachment Records	NA
95-08	Accommodations Total Charges for the Batch	NA
95-09	Accommodations Noncovered Charges for the Batch	NA
95-10	Ancillary Total Charges for the Batch	NA
95-11	Ancillary Noncovered Charges for the Batch	NA
95-12	Filler (National Use)	
95-13	Filler (Local Use)	

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99-01	Record Type	NA
99-02	Submitter EIN	1 020 NM109
99-03	Receiver Identification	NA
99-04	Receiver Sub-Identification	NA
99-05	Number of Batches Billed this File	NA
99-06	Accommodations Total Charges for the File	NA
99-07	Accommodations Noncovered Charges for the File	NA
99-08	Ancillary Total Charges for the File	NA
99-09	Ancillary Noncovered Charges for the File	NA
99-10	Filler (National Use)	
99-11	Filler (Local Use)	

Commented 837 Example

```
ISA*00*.....*01*SECRET....*ZZ*MEDEX.....*ZZ*0305.....*930602*1253*U*00304*000000905*1*T*:~
GS*HC*MEDEX*0305*930602*1253*1*X*003051~
ST*837*112233~
BGN*00*C10027*930704~
REF*F1*3A~
NM1*41*2*HOSPITAL BILLING SERVICE*****24*731234567~
N3*123 MAIN STREET~
N4*ANY TOWN*TX*75123~
PER*SM*JANE DOE*TE*2145551212~
PRV*BI*1C*IM0345~
NM1*85*2*GOOD SAMARITAN~
N3*35 W ELM ST*SUITE 101~
N4*ANY TOWN*TX*75124~
PER*PH**TE*8175551212~
SBR*P********MA~
PAT*18**RT~
NM1*QC*1*JOE*JOHN****HN*123234567A~
N3*44 W 1500 SOUTH ST~
N4*ANY TOWN*TX*75122~
DMG*D8*19181105*M~
PER*PZ**TE*8175551212~
REF*EA*9300456~
CLM*DOJ 023479 1*25.25*MA**A:11:1***Y*Y~
DTP*232*D8*19930120~
DTP*233*D8*19941020~
DTP*096*TM*1020~
CL1*3*2*30~
AMT*F5*5.25~
AMT*F3*3.2~
REF*F8*931278760100~
REF*N9*9~
NTE*ADD*No liability, patient fell at home~
NTE*NTR*PATIENT REQUIRES TUBE FEEDING~
CRC*75*Y*AL~
CRC*76*Y*CB~
CRC*77*Y*DI~
QTY*CA*5*DA~
QTY*NA*2*DA~
QTY*CD*2*DA~
QTY*LA*100*DA~
CR7*SN*12*15~
HSD*VS*2*WK**7*090~
```

```
LS*2310~
NM1*71*1*ZUBELDIA*KEPA****UP*C12345~
N4*****75122~
NM1*72*1*ZUBELDIA*KEPA****UP*A01234~
NM1*73*1*SMITH*JOHN*I***UP*B12365~
NM1*DK*2*SMITH*JOHN*I***UP*B12365~
LE*2310~
LS*2320~
SBR*S*18*0001234*GOLDEN GAP*MG~
AMT*D*150~
AMT*C5*575~
DMG*D8*18961105*F~
OI*CI~
NM1*PR*2*NATIONAL RETIREMENT*****PI*NR002~
REF*BB*9300007891~
REF*G2*731234567~
REF*F8*931278760100~
NM1*IL*1*ZUBELDIA*LESLIE*B**C1*464675489~
N3*44 W1500 SOUTH ST~
N4*ANYTOWN*TX*75122~
NM1*84*2*ACME BRICK~
N3*Industrial Drive~
N4*Somewhere*TX*75122~
NM1*ES*2*BROADWAY FORD~
N3*Industrial Drive~
N4*Somewhere*TX*75122~
REF*ZZ*FT~
LE*2320~
LX*1~
SV2*0305*HC:99211*25*UN*5~
DTP*472*D8*19930122~
SE*1230*112233~
GE*1*1~
IEA*1*000000905~
```

Actual 837 from example

ISA*00*.....*01*SECRET....*ZZ*MEDEX.....*ZZ*03330.....*930602*125
3*U*00304*0000009051*T*:~GS*HC*MEDEX*03330*930602*1253*1*X*003051~ST*837*112233~
BGN*00*C10027*930704~REF*F1*3A~NM1*41*2*HOSPITAL BILLING SERVICE*****24*73123456
7~N3*123 MAIN STREET~N4*ANY TOWN*TX*75123~PER*SM*JANE DOE*TE*2145551212~PRV*BI*1
C*IM0345~NM1*85*2*GOOD SAMARITAN~N3*35 W ELM ST*SUITE 101~N4*ANY TOWN*TX*75124~P
ER*PH**TE*8175551212~SBR*P********MA~PAT*18**RT~NM1*QC*1*JOE*JOHN****HN*12323456
7A~N3*44 W 1500 SOUTH ST~N4*ANY TOWN*TX*75122~DMG*D8*19181105*M~PER*PZ**TE*81755
51212~REF*EA*9300456~CLM*DOJ 023479
1*25.25*MA**A:11:1***Y*Y~DTP*232*D8*19930120~DTP*233*D8*19941020~DTP*096*TM*1020~CL1*3*2*30~
AMT*F5*5.25~AMT*F3*3.2~REF*F
8*931278760100~REF*N9*9~NTE*ADD*No liability, patient fell at home~NTE*NTR*PATIE
NT REQUIRES TUBE FEEDING~CRC*75*Y*AL~CRC*76*Y*CB~CRC*77*Y*DI~QTY*CA*5*DA~QT
Y*NA*2*DA~QTY*CD*2*DA~QTY*LA*100*DA~CR7*SN*12*15~HSD*VS*2*WK**7*090~LS*2310~NM1*
71*1*ZUBELDIA*KEPA****UP*C12345~N4*****75122~NM1*72*1*ZUBELDIA*KEPA****UP*A01234
~NM1*73*1*SMITH*JOHN*I***UP*B12365~NM1*DK*2*SMITH*JOHN*I***UP*B12365~LE*2310~LS*
2320~SBR*S*18*0001234*GOLDEN GAP*MG~AMT*D*150~AMT*C5*575~DMG*D8*18961105*F~OI*CI
~NM1*PR*2*NATIONAL RETIREMENT*****PI*NR002~REF*BB*9300007891~REF*G2*731234567~RE
F*F8*931278760100~NM1*IL*1*ZUBELDIA*LESLIE*B**C1*464675489~N3*44 W1500 SOUTH ST~
N4*ANYTOWN*TX*75122~NM1*84*2*ACME BRICK~N3*Industrial Drive~N4*Somewhere*TX*75122
~NM1*ES*2*BROADWAY FORD~N3*Industrial Drive~N4*Somewhere*TX*75122~REF*ZZ*FT~LE*2
320~LX*1~SV2*0305*HC:99211*25*UN*5~DTP*472*D8*19930122~SE*1230*112233~GE*1*1~IEA*1
*000000905~

The Medicare A 837 transaction set is used to submit a claim to Medicare for Medicare payment. Medicare can be either the primary or secondary payer. When Medicare is the secondary payer, primary payer information MUST be supplied. In some situations, after Medicare adjudicates a claim, Medicare will forward the claim to one or two supplementary payer(s) for additional payment. The Medicare A 837 transaction set is used to identify the supplemental payer(s).

A. How to Indicate Whether Medicare is Primary or Secondary

When Medicare is the primary payer, send a "P" in segment SBR (Position 045). DO NOT send any information in loop 2320.

When Medicare is the secondary payer, send "S" in segment SBR (Position 045). Loop 2320 is REQUIRED.

B. How to Indicate Other Payers Supplementary to Medicare

The Medicare A 837 transaction set will accommodate a total of three payers including Medicare. These can be (1) Medicare as primary payer and a maximum of two supplemental payers, or (2) another primary payer, Medicare as secondary payer, and a maximum of one supplemental payer.

Supply supplementary insurance information in loop 2320. When Medicare is the primary payer, up to two repetitions of loop 2320 are allowed. When Medicare is secondary, up to one loop 2320 is allowed.

If Medicare is primary and the patient has other insurance coverage, such supplementary coverage will be mapped to loop 2320.

Medicare as Secondary Payer - If the patient has other primary insurance and Medicare is secondary, the UB92 requires a separate 30 record for each payer. The first 30 record carries information about the primary payer, the second 30 holds information about the secondary payer (Medicare A).

Report the Employer's name if the insured's policy is an employer group plan.

Medicare as Tertiary Payer - If the patient has other primary and secondary insurance coverage, and Medicare is tertiary, the UB92 requires a separate 30 record for each payer. The first 30 record carries information about the primary payer, the second 30 record holds information about the secondary payer. The third 30 record carries information about the tertiary payer (Medicare A).

Only report the policy holder (Insured) name, ID number, address and demographics if patient is not the insured on secondary payers policy.

Report the Employer's name if the insured's policy is an employer group plan.

Supplementary Coverage - If the patient has other insurance coverage supplementary or Medicare, if Medicare is Primary, the supplementary coverage will be secondary, and if Medicare is Secondary, the supplementary coverage will be tertiary.

Report the supplementary payer name, ID, and address as required.

Only report the supplementary policy holder (Insured) name, ID number, address and demographics if patient is not the insured on primary supplementary policy.

997 Functional Acknowledgment

This Draft Standard for Trial Use contains the format and establishes the data contents of the Functional Acknowledgment Transaction Set (997) for use within the context of an Electronic Data Interchange (EDI) environment. The transaction set can be used to define the control structures for a set of acknowledgments to indicate the results of the syntactical analysis of the electronically encoded documents. The encoded documents are the transaction sets, which are grouped in functional groups, used in defining transactions for business data interchange. This standard does not cover the semantic meaning of the information encoded in the transaction sets.

The functional acknowledgment provides the acknowledgment of receipt.

TABLE 0

Nte	Pos.	Seg.	Name	Req.	Max.Use	Loop Repeat
	010	ISA	Interchange Control Header	M	1	
	015	TA1	Interchange Acknowledgment	O	1	
	020	GS	Functional Group Header	M	1	

TABLE 1

Nte	Pos.	Seg.	Name	Req.	Max.Use	Loop Repeat
N	010	ST	Transaction Set Header	M	1	
N	020	AK1	Functional Group Response Header	M	1	
			LOOP ID - AK2			999999
N	030	AK2	Transaction Set Response Header	O	1	
			LOOP ID - AK3			999999
C	040	AK3	Data Segment Note	O	1	
	050	AK4	Data Element Note	O	99	
	060	AK5	Transaction Set Response Trailer	M	1	
	070	AK9	Functional Group Response Trailer	M	1	
	080	SE	Transaction Set Trailer	M	1	

TABLE 4

Nte Pos.	Seg. Name		Req.	Max.Use	Loop Repeat
010	GE	Functional Group Trailer	M	1	
020	IEA	Interchange Control Trailer	M	1	

Table 1 Position 010 Note 2:
These acknowledgments shall not be acknowledged, thereby preventing an endless cycle of acknowledgments of acknowledgments.

Table 1 Position 010 Note 3:
The Functional Group Header Segment (GS) is used to start the envelope for the Functional Acknowledgment Transaction Sets. In preparing the functional group of acknowledgments, the application sender's code and the application receiver's code, taken from the functional group being acknowledged, are exchanged; therefore, one acknowledgment functional group responds to only those functional groups from one application receiver's code to one application sender's code.

Table 1 Position 010 Note 4:
There is only one Functional Acknowledgment Transaction Set per acknowledged functional group.

Table 1 Position 020 Note 1:
AK1 is used to respond to the functional group header and to start the acknowledgment for a functional group. There shall be one AK1 segment for the functional group that is being acknowledged.

Table 1 Position 030 Note 1:
AK2 is used to start the acknowledgment of a transaction set within the received functional group. The AK2 segments shall appear in the same order as the transaction sets in the functional group that has been received and is being acknowledged.

Table 1 Position 040 Comment 1:
The data segments of this standard are used to report the results of the syntactical analysis of the functional groups of transaction sets; they report the extent to which the syntax complies with the standards for transaction sets and functional groups. They do not report on the semantic meaning of the transaction sets (for example, on the ability of the receiver to comply with the request of the sender).

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X12 Segment Name: ISA Interchange Control Header
Loop: ----
Max. Use: 1
X12 Purpose: To start and identify an interchange of zero or more functional groups and interchange-related control segments
Usage: Mandatory
Example: ISA*00*.....*01*SECRET....*ZZ*03330.....*
ZZ*MEDEX.....*930602*1257*U*00305*000000912*1*T*:~
Comments: The ISA is a fixed record length segment and all positions within each of the data elements must be filled. The first element separator defines the element separator to be used through the entire exchange. The segment terminator used after the ISA defines the segment terminator to be used throughout the entire exchange.
The white spaces in the example have been replaced by periods for clarity.

Element Attributes	Data Element Usage
ISA01 I01 ID 2 2 M	Authorization Information Qualifier Code to identify the type of information in the Authorization Information. Codes: 00 No Authorization Information Present (No Meaningful Information in I02) 03 Additional Data Identification
ISA02 I02 AN 10 10 M	Authorization Information Information used for additional identification or authorization of the interchange sender or the data in the interchange; the type of information is set by the Authorization Information Qualifier (I01)
ISA03 I03 ID 2 2 M	Security Information Qualifier Code to identify the type of information in the Security Information. Codes: 00 No Security Information Present (No Meaningful Information in I04) 01 Password
ISA04 I04 AN 10 10 M	Security Information This is used for identifying the security information about the interchange sender or the data in the

interchange; the type of information is set by the Security Information Qualifier (I03)

ISA05 I05 ID 2 2 M
Interchange ID Qualifier
Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified.
Codes:
ZZ Mutually Defined

ISA06 I06 AN 15 15 M
Interchange Sender ID
Carrier Identification Number
Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element
The identification code for the receiver of this transmission.

ISA07 I05 ID 2 2 M
Interchange ID Qualifier
Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified.
Codes:
ZZ Mutually Defined

ISA08 I07 AN 15 15 M
Interchange Receiver ID
Transmission Submitter Identification Number
Identification code published by the receiver of the data. When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them.
The identification code assigned by the carrier to the submitter of this transmission. Space fill the submitter number to the right for a total length of 15 characters.

ISA09 I08 DT 6 6 M
Interchange Date
File Creation Date
Date of the interchange.
Format YYMMDD.

ISA10 I09 Interchange Time
TM 4 4 M File Creation Time
Time of the interchange.
Format HHMM. Use a minimum of four zeroes if there is no significant data for this field.

ISA11 I10 Interchange Control Standards Identifier
ID 1 1 M Code to identify the agency responsible for the control standard used by the message that is enclosed by the interchange header and trailer.
Codes:
U U.S. EDI Community of ASC X12, TDCC, and UCS

ISA12 I11 Interchange Control Version Number
ID 5 5 M ANSI Version Code
This version number covers the interchange control segments.
The version code may vary, if or when HCFA chooses to adopt the next ASC X12 Version. The correct code for this version is "00305".
Codes:

ISA13 I12 Interchange Control Number
N0 9 9 M A control number assigned by the interchange sender
The Interchange Control Number, ISA13, must be identical to the one found in the associated Interchange Trailer IEA02. Cannot be left blank.

ISA14 I13 Acknowledgment Requested
ID 1 1 M Code sent by the sender to request an interchange acknowledgment (TA1)
Codes:
0 No Acknowledgment Requested
1 Interchange Acknowledgment Requested

ISA15 I14 Test Indicator
ID 1 1 M Code to indicate whether data enclosed by this interchange envelope is test or production.
Codes:
P Production Data
T Test Data

ISA16	I15	Component Element Separator
AN	1 1 M	This field provides the delimiter used to separate component data elements within a composite data structure; this value must be different than the data element separator and the segment terminator Cannot be left blank. ':' is recommended.

X12 Segment Name: TA1 Interchange Acknowledgment
Loop: ----
Max. Use: 1
X12 Purpose: To report the status of processing a received interchange header and trailer or the non-delivery by a network provider
Usage: Optional
Example: TA1*000000905*930602*1253*A*000~
Comments: All fields must contain data.
This segment acknowledges the reception of an X12 interchange header and trailer from a previous interchange. If the header/trailer pair was received correctly the TA1 will reflect it, regardless of the validity of the contents of the data included inside the header/trailer envelope.

Element Attributes	Data Element Usage
TA101 I12 N0 9 9 M	Interchange Control Number A control number assigned by the interchange sender
TA102 I08 DT 6 6 M	Interchange Date Date of the interchange.
TA103 I09 TM 4 4 M	Interchange Time Time of the interchange.
TA104 I17 ID 1 1 M	Interchange Acknowledgment Code This indicates the status of the receipt of the interchange control structure. Codes: A The Transmitted Interchange Control Structure Header and Trailer Have Been Received and Have No Errors. E The Transmitted Interchange Control Structure Header and Trailer Have Been Received and Are Accepted But Errors Are Noted. This Means the Sender Must Not Resend This Data. R The Transmitted Interchange Control Structure Header and Trailer are Rejected Because of Errors.
TA105 I18 ID 3 3 M	Interchange Note Code This numeric code indicates the error

found processing the interchange
control structure.
Codes:
000 No error
001 The Interchange Control Number in the Header and Trailer Do Not Match. The Value From the Header is Used in the Acknowledgment.
002 This Standard as Noted in the Control Standards Identifier is Not Supported.
003 This Version of the Controls is Not Supported
004 The Segment Terminator is Invalid
005 Invalid Interchange ID Qualifier for Sender
006 Invalid Interchange Sender ID
007 Invalid Interchange ID Qualifier for Receiver
008 Invalid Interchange Receiver ID
009 Unknown Interchange Receiver ID
010 Invalid Authorization Information Qualifier Value
011 Invalid Authorization Information Value
012 Invalid Security Information Qualifier Value
013 Invalid Security Information Value
014 Invalid Interchange Date Value
015 Invalid Interchange Time Value
016 Invalid Interchange Standards Identifier Value
017 Invalid Interchange Version ID Value
018 Invalid Interchange Control Number Value
019 Invalid Acknowledgment Requested Value
020 Invalid Test Indicator Value
021 Invalid Number of Included Groups Value
022 Invalid Control Structure
023 Improper (Premature) End-of-File (Transmission)
024 Invalid Interchange Content (e.g., Invalid GS Segment)
025 Duplicate Interchange Control Number
026 Invalid Data Element Separator
027 Invalid Component Element Separator
028 Invalid Delivery Date in Deferred Delivery Request
029 Invalid Delivery Time in Deferred Delivery Request
030 Invalid Delivery Time Code in

Deferred Delivery Request
031 Invalid Grade of Service Code

X12 Segment Name: GS Functional Group Header
Loop: ----
Max. Use: 1
X12 Purpose: To indicate the beginning of a functional group and to provide control information
Usage: Mandatory
Example: GS*FA*03330*MEDEX*930602*1257*1*X*003051~
Comments: All fields must contain data.

Semantic Note: GS04 is the Group Date.
Semantic Note: GS05 is the Group Time.
Semantic Note: The data interchange control number GS06 in this header must be identical to the same data element in the associated Functional Group Trailer GE02.

X12 Comment: A functional group of related transaction sets, within the scope of X12 standards, consists of a collection of similar transaction sets enclosed by a functional group header and a functional group trailer.

Element Attributes	Data Element Usage
GS01	0479 Functional Identifier Code
ID 2 2	M Code identifying a group of application related Transaction Sets. Codes: FA Functional Acknowledgment (997)
GS02	0142 Application Sender's Code
AN 2 15	M Carrier Identification Number Code identifying party sending transmission. Codes agreed to by trading partners. The identification code for the receiver of this transmission.
GS03	0124 Application Receiver's Code
AN 2 15	M Transmission Submitter Identification Number Code identifying party receiving transmission. Codes agreed to by trading partners. The identification code assigned by the carrier to the submitter of this transmission.
GS04	0373 Date
DT 6 6	M Group Creation Date Date (YYMMDD).

GS05 0337 Time
TM 4 8 M Group Creation Time
Time expressed in 24-hour clock time as follows: HHMM, or HHMMSS, or HHMMSSD, or HHMMSSDD, where H = hours (00-23), M = minutes (00-59), S = integer seconds (00-59) and DD = decimal seconds; decimal seconds are expressed as follows: D = tenths (0-9) and DD = hundredths (00-99)
Format HHMM. Use a minimum of four zeroes if there is no significant data for this field.

GS06 0028 Group Control Number
N0 1 9 M Assigned number originated and maintained by the sender.
The group control number, GS06, must be identical to the one found in the associated function trailer GE02. Start with 1 and increment by 1 for each functional group within this interchange.

GS07 0455 Responsible Agency Code
ID 1 2 M Code used in conjunction with Data Element 480 to identify the issuer of the standard.
Codes:
X Accredited Standards Committee X12

GS08 0480 Version / Release / Industry Identifier
AN 1 12 M Code
ANSI Version Code
Code indicating the version, release, subrelease, and industry identifier of the EDI standard being used, including the GS and GE segments. If code in DE455 in GS segment is X, then in DE 480 positions 1-3 are the version number; positions 4-6 are the release and subrelease, level of the version; and positions 7-12 are the industry or trade association identifiers (optionally assigned by user). If code in DE455 in GS segment is T, then other formats are allowed.
The version code may vary, if or when HCFA chooses to adopt the next ASC X12 Version
Codes:
003051 Draft Standards Approved for Publication by ASC X12 Procedures

Review Board through February 1995

X12 Segment Name: ST Transaction Set Header
Loop: ----
Max. Use: 1
X12 Purpose: To indicate the start of a transaction set and to assign a control number
Usage: Mandatory
Example: ST*997*456123~

Semantic Note: The transaction set identifier (ST01) used by the translation routines of the interchange partners to select the appropriate transaction set definition (e.g., 810 selects the invoice transaction set).

Element Attributes		Data Element Usage
ST01	0143	Transaction Set Identifier Code
ID 3	3 M	Code uniquely identifying a Transaction Set. Codes: 997 X12.20 Functional Acknowledgment
ST02	0329	Transaction Set Control Number
AN 4	9 M	Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set

X12 Segment Name: AK1 Functional Group Response Header
Loop: ----
Max. Use: 1
X12 Purpose: To start acknowledgment of a functional group.
Usage: Mandatory
Example: AK1*HC*1~

Semantic Note: AK101 is the functional ID found in the GS segment (GS01) in the functional group being acknowledged.
Semantic Note: AK102 is the functional group control number found in the GS segment in the functional group being acknowledged.

Element Attributes	Data Element Usage
AK101 0479 Functional Identifier Code ID 2 2	M Code identifying a group of application related Transaction Sets. Codes: HC Health Care Claim (837)
AK102 0028 Group Control Number N0 1 9	M Assigned number originated and maintained by the sender.

X12 Segment Name: AK2 Transaction Set Response Header
Loop: AK2
Max. Use: 1
X12 Purpose: To start acknowledgment of a single transaction set.
Usage: Optional
Example: AK2*837*112233~

Semantic Note: AK201 is the transaction set ID found in the ST segment (ST01) in the transaction set being acknowledged.
Semantic Note: AK202 is the transaction set control number found in the ST segment in the transaction set being acknowledged.

Element Attributes		Data Element Usage
AK201	0143 Transaction Set Identifier Code	
ID 3	3 M	Code uniquely identifying a Transaction Set. Codes: 837 X12.86 Health Care Claim
AK202	0329 Transaction Set Control Number	
AN 4	9 M	Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set

X12 Segment Name: AK3 Data Segment Note
Loop: AK3
Max. Use: 1
X12 Purpose: To report errors in a data segment and to identify the location of the data segment.
Usage: Optional
Example: AK3*NM1*95*2210*3~

Element Attributes	Data Element Usage
AK301 0721 Segment ID Code ID 2 3 M	Code defining the segment ID of the data segment in error. See Appendix A - Number 77.
AK302 0719 Segment Position in Transaction Set N0 1 6 M	The numerical count position of this data segment from the start of the transaction set: the transaction set header is count position 1.
AK303 0447 Loop Identifier Code AN 1 4 O	The loop ID number given on the transaction set diagram is the value for this data element in segments LS and LE
AK304 0720 Segment Syntax Error Code ID 1 3 O	Code indicating error found based on the syntax editing of a segment Codes: 1 Unrecognized segment ID 2 Unexpected segment 3 Mandatory segment missing 4 Loop Occurs Over Maximum Times 5 Segment Exceeds Maximum Use 6 Segment Not in Defined Transaction Set 7 Segment Not in Proper Sequence 8 Segment Has Data Element Errors

X12 Segment Name: AK4 Data Element Note
Loop: AK3
Max. Use: 99
X12 Purpose: To report errors in a data element and to identify the location of the data element.
Usage: Optional
Example: AK4*9*67*1~

Element Attributes	Data Element Usage
AK401 C030	Position in Segment Composit M Code indicating the relative position of a simple data element, or the relative position of a composite data structure combined with the relative position of the component data element within the composite data structure, in error; the count starts with 1 for the simple data element or composite data structure immediately following the segment ID
*-01 0722	Element Position in Segment N0 1 2 M This is used to indicate the relative position of a simple data element, or the relative position of a composite data structure with the relative position of the component within the composite data structure, in error; in the data segment the count starts with 1 for the simple data element or composite data structure immediately following the segment ID
*-02 1528	Component Data Element Position in N0 1 2 O Composite To identify the component data element position within the composite that is in error
AK402 0725	Data Element Reference Number N0 1 4 O Reference number used to locate the data element in the Data Element Dictionary.
AK403 0723	Data Element Syntax Error Code ID 1 3 M Code indicating the error found after syntax edits of a data element. Codes: 1 Mandatory data element missing

2 Conditional required data element missing.
3 Too many data elements.
4 Data element too short.
5 Data element too long.
6 Invalid character in data element.
7 Invalid code value.
8 Invalid Date
9 Invalid Time
10 Exclusion Condition Violated

AK404 0724 Copy of Bad Data Element
AN 1 99 O This is a copy of the data element in error.

X12 Segment Name: AK5 Transaction Set Response Trailer
Loop: AK2
Max. Use: 1
X12 Purpose: To acknowledge acceptance or rejection and to report errors in a transaction set.
Usage: Mandatory
Example: AK5*E*5~

Element Attributes	Data Element Usage
AK501 0717	Transaction Set Acknowledgment Code ID 1 1 M Code indicating accept or reject condition based on the syntax editing of the transaction set. Codes: A Accepted E Accepted But Errors Were Noted M Rejected, Message Authentication Code (MAC) Failed R Rejected X Rejected, Content After Decryption Could Not Be Analyzed
AK502 0718	Transaction Set Syntax Error Code ID 1 3 O Code indicating error found based on the syntax editing of a transaction set. Codes: 1 Transaction Set Not Supported 2 Transaction Set Trailer Missing 3 Transaction Set Control Number in Header and Trailer Do Not Match 4 Number of Included Segments Does Not Match Actual Count 5 One or More Segments in Error 6 Missing or Invalid Transaction Set Identifier 7 Missing or Invalid Transaction Set Control Number 8 Authentication Key Name Unknown 9 Encryption Key Name Unknown 10 Requested Service (Authentication or Encrypted) Not Available 11 Unknown Security Recipient 12 Incorrect Message Length (Encryption Only) 13 Message Authentication Code Failed 15 Unknown Security Originator 16 Syntax Error in Decrypted Text 17 Security Not Supported 19 S1E Security End Segment Missing for S1S Security Start Segment 20 S1S Security Start Segment Missing for S1E Security End

Segment
21 S2E Security End Segment Missing
for S2S Security Start Segment
22 S2S Security Start Segment
Missing for S2E Security End Segment
23 Transaction Set Control Number
Not Unique within the Functional Group

AK503 0718 Transaction Set Syntax Error Code
ID 1 3 O Code indicating error found based on
the syntax editing of a transaction set.
Codes:
1 Transaction Set Not Supported
2 Transaction Set Trailer Missing
3 Transaction Set Control Number in
Header and Trailer Do Not Match
4 Number of Included Segments Does
Not Match Actual Count
5 One or More Segments in Error
6 Missing or Invalid Transaction
Set Identifier
7 Missing or Invalid Transaction
Set Control Number
8 Authentication Key Name Unknown
9 Encryption Key Name Unknown
10 Requested Service (Authentication
or Encrypted) Not Available
11 Unknown Security Recipient
12 Incorrect Message Length
(Encryption Only)
13 Message Authentication Code Failed
15 Unknown Security Originator
16 Syntax Error in Decrypted Text
17 Security Not Supported
19 S1E Security End Segment Missing
for S1S Security Start Segment
20 S1S Security Start Segment
Missing for S1E Security End
Segment
21 S2E Security End Segment Missing
for S2S Security Start Segment
22 S2S Security Start Segment
Missing for S2E Security End Segment
23 Transaction Set Control Number
Not Unique within the Functional Group

AK504 0718 Transaction Set Syntax Error Code
ID 1 3 O Code indicating error found based on
the syntax editing of a transaction set.
Codes:

1 Transaction Set Not Supported
2 Transaction Set Trailer Missing
3 Transaction Set Control Number in Header and Trailer Do Not Match
4 Number of Included Segments Does Not Match Actual Count
5 One or More Segments in Error
6 Missing or Invalid Transaction Set Identifier
7 Missing or Invalid Transaction Set Control Number
8 Authentication Key Name Unknown
9 Encryption Key Name Unknown
10 Requested Service (Authentication or Encrypted) Not Available
11 Unknown Security Recipient
12 Incorrect Message Length (Encryption Only)
13 Message Authentication Code Failed
15 Unknown Security Originator
16 Syntax Error in Decrypted Text
17 Security Not Supported
19 S1E Security End Segment Missing for S1S Security Start Segment
20 S1S Security Start Segment Missing for S1E Security End Segment
21 S2E Security End Segment Missing for S2S Security Start Segment
22 S2S Security Start Segment Missing for S2E Security End Segment
23 Transaction Set Control Number Not Unique within the Functional Group

AK505 0718 Transaction Set Syntax Error Code
ID 1 3 O Code indicating error found based on the syntax editing of a transaction set.
Codes:
1 Transaction Set Not Supported
2 Transaction Set Trailer Missing
3 Transaction Set Control Number in Header and Trailer Do Not Match
4 Number of Included Segments Does Not Match Actual Count
5 One or More Segments in Error
6 Missing or Invalid Transaction Set Identifier
7 Missing or Invalid Transaction Set Control Number
8 Authentication Key Name Unknown
9 Encryption Key Name Unknown
10 Requested Service (Authentication or Encrypted) Not Available

11 Unknown Security Recipient
12 Incorrect Message Length
(Encryption Only)
13 Message Authentication Code Failed
15 Unknown Security Originator
16 Syntax Error in Decrypted Text
17 Security Not Supported
19 S1E Security End Segment Missing
for S1S Security Start Segment
20 S1S Security Start Segment
Missing for S1E Security End Segment
21 S2E Security End Segment Missing
for S2S Security Start Segment
22 S2S Security Start Segment
Missing for S2E Security End Segment
23 Transaction Set Control Number
Not Unique within the Functional
Group

AK506 0718 Transaction Set Syntax Error Code
ID 1 3 O Code indicating error found based on
the syntax editing of a transaction set.
Codes:
1 Transaction Set Not Supported
2 Transaction Set Trailer Missing
3 Transaction Set Control Number in
Header and Trailer Do Not Match
4 Number of Included Segments Does
Not Match Actual Count
5 One or More Segments in Error
6 Missing or Invalid Transaction Set Identifier
7 Missing or Invalid Transaction
Set Control Number
8 Authentication Key Name Unknown
9 Encryption Key Name Unknown
10 Requested Service (Authentication
or Encrypted) Not Available
11 Unknown Security Recipient
12 Incorrect Message Length (Encryption Only)
13 Message Authentication Code Failed
15 Unknown Security Originator
16 Syntax Error in Decrypted Text
17 Security Not Supported
19 S1E Security End Segment Missing
for S1S Security Start Segment
20 S1S Security Start Segment
Missing for S1E Security End Segment
21 S2E Security End Segment Missing
for S2S Security Start Segment
22 S2S Security Start Segment

Missing for S2E Security End Segment

23 Transaction Set Control Number Not Unique within the Functional Group

X12 Segment Name: AK9 Functional Group Response Trailer
Loop: ----
Max. Use: 1
X12 Purpose: To acknowledge acceptance or rejection of a functional group and report the number of included transaction sets from the original trailer, the accepted sets, and the received sets in this functional group.
Usage: Mandatory
Example: AK9*A*1*1*1~

X12 Comment: If AK901 is 'A' or 'E', then the transmitted functional group is accepted. If AK901 is 'R', then the transmitted group is rejected.

Element Attributes	Data Element Usage
AK901 0715 Functional Group Acknowledge Code ID 1 1 M	Code indicating accept or reject condition based on the syntax editing of the functional group. Codes: A Accepted E Accepted, But Errors Were Noted. M Rejected, Message Authentication Code (MAC) Failed P Partially Accepted, At Least One Transaction Set Was Rejected R Rejected X Rejected, Content After Decryption Could Not Be Analyzed
AK902 0097 Number of Transaction Sets Included N0 1 6 M	Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element.
AK903 0123 Number of Received Transaction Sets N0 1 6 M	Number of Transaction Sets received.
AK904 0002 Number of Accepted Transaction Sets N0 1 6 M	Number of accepted Transaction Sets in a Functional Group.
AK905 0716 Functional Group Syntax Error Code ID 1 3 O	Code indicating error found based on the syntax editing of the functional group header and/or trailer. Codes:

1 Functional Group Not Supported
2 Functional Group Version Not Supported
3 Functional Group Trailer Missing
4 Group Control Number in the Functional Group Header and Trailer Do Not Agree
5 Number of Included Transaction Sets Does Not Match Actual Count
6 Group Control Number Violates Syntax
10 Authentication Key Name Unknown
11 Encryption Key Name Unknown
12 Requested Service (Authentication or Encryption) Not Available
13 Unknown Security Recipient
14 Unknown Security Originator
15 Syntax Error in Decrypted Text
16 Security Not Supported
17 Incorrect Message Length (Encryption Only)
18 Message Authentication Code Failed
19 S1E Security End Segment Missing for S1S Security Start Segment
20 S1S Security Start Segment Missing for S1E End Segment
21 S2E Security End Segment Missing for S2S Security Start Segment
22 S2S Security Start Segment Missing for S2E Security End Segment

AK906 0716 Functional Group Syntax Error Code
ID 1 3 O Code indicating error found based on the syntax editing of the functional group header and/or trailer.
Codes:
1 Functional Group Not Supported
2 Functional Group Version Not Supported
3 Functional Group Trailer Missing
4 Group Control Number in the Functional Group Header and Trailer Do Not Agree
5 Number of Included Transaction Sets Does Not Match Actual Count
6 Group Control Number Violates Syntax
10 Authentication Key Name Unknown
11 Encryption Key Name Unknown
12 Requested Service (Authentication or Encryption) Not Available
13 Unknown Security Recipient
14 Unknown Security Originator
15 Syntax Error in Decrypted Text

16 Security Not Supported
17 Incorrect Message Length
(Encryption Only)
18 Message Authentication Code Failed
19 S1E Security End Segment Missing
for S1S Security Start Segment
20 S1S Security Start Segment
Missing for S1E End Segment
21 S2E Security End Segment Missing
for S2S Security Start Segment
22 S2S Security Start Segment
Missing for S2E Security End Segment

AK907 0716 Functional Group Syntax Error Code
ID 1 3 O Code indicating error found based on
the syntax editing of the functional
group header and/or trailer.
Codes:
1 Functional Group Not Supported
2 Functional Group Version Not Supported
3 Functional Group Trailer Missing
4 Group Control Number in the
Functional Group Header and
Trailer Do Not Agree
5 Number of Included Transaction
Sets Does Not Match Actual Count
6 Group Control Number Violates Syntax
10 Authentication Key Name Unknown
11 Encryption Key Name Unknown
12 Requested Service (Authentication
or Encryption) Not Available
13 Unknown Security Recipient
14 Unknown Security Originator
15 Syntax Error in Decrypted Text
16 Security Not Supported
17 Incorrect Message Length (Encryption Only)
18 Message Authentication Code Failed
19 S1E Security End Segment Missing
for S1S Security Start Segment
20 S1S Security Start Segment
Missing for S1E End Segment
21 S2E Security End Segment Missing
for S2S Security Start Segment
22 S2S Security Start Segment
Missing for S2E Security End
Segment

AK908 0716 Functional Group Syntax Error Code
ID 1 3 O Code indicating error found based on
the syntax editing of the functional

group header and/or trailer.
Codes:
1 Functional Group Not Supported
2 Functional Group Version Not Supported
3 Functional Group Trailer Missing
4 Group Control Number in the Functional Group Header and Trailer Do Not Agree
5 Number of Included Transaction Sets Does Not Match Actual Count
6 Group Control Number Violates Syntax
10 Authentication Key Name Unknown
11 Encryption Key Name Unknown
12 Requested Service (Authentication or Encryption) Not Available
13 Unknown Security Recipient
14 Unknown Security Originator
15 Syntax Error in Decrypted Text
16 Security Not Supported
17 Incorrect Message Length (Encryption Only)
18 Message Authentication Code Failed
19 S1E Security End Segment Missing for S1S Security Start Segment
20 S1S Security Start Segment Missing for S1E End Segment
21 S2E Security End Segment Missing for S2S Security Start Segment
22 S2S Security Start Segment Missing for S2E Security End Segment

AK909 0716 Functional Group Syntax Error Code
ID 1 3 O Code indicating error found based on the syntax editing of the functional group header and/or trailer.
Codes:
1 Functional Group Not Supported
2 Functional Group Version Not Supported
3 Functional Group Trailer Missing
4 Group Control Number in the Functional Group Header and Trailer Do Not Agree
5 Number of Included Transaction Sets Does Not Match Actual Count
6 Group Control Number Violates Syntax
10 Authentication Key Name Unknown
11 Encryption Key Name Unknown
12 Requested Service (Authentication or Encryption) Not Available
13 Unknown Security Recipient

14 Unknown Security Originator
15 Syntax Error in Decrypted Text
16 Security Not Supported
17 Incorrect Message Length (Encryption Only)
18 Message Authentication Code Failed
19 S1E Security End Segment Missing for S1S Security Start Segment
20 S1S Security Start Segment Missing for S1E End Segment
21 S2E Security End Segment Missing for S2S Security Start Segment
22 S2S Security Start Segment Missing for S2E Security End Segment

X12 Segment Name: SE Transaction Set Trailer
Loop: ----
Max. Use: 1
X12 Purpose: To indicate the end of the transaction set and provide the count of the transmitted segments (including the beginning (ST) and ending (SE) segments).
Usage: Mandatory
Example: SE*1230*112233~

X12 Comment: SE is the last segment of each transaction set.

Element Attributes	Data Element Usage
SE01	0096 Number of Included Segments
N0 1 10 M	Total number of segments included in a transaction set including ST and SE segments.
SE02	0329 Transaction Set Control Number
AN 4 9 M	Identifying control number that must be unique within the transaction set functional group assigned by the originator for a transaction set

X12 Segment Name: GE Functional Group Trailer
Loop: ----
Max. Use: 1
X12 Purpose: To indicate the end of a functional group and to provide control information
Usage: Mandatory
Example: GE*1*1~

Semantic Note: The data interchange control number GE02 in this trailer must be identical to the same data element in the associated Functional Header GS06.

X12 Comment: The use of identical data interchange control numbers in the associated functional group header and trailer is designed to maximize functional group integrity. The control number is the same as that used in the corresponding header.

Element Attributes	Data Element Usage
GE01	0097 Number of Transaction Sets Included
N0 1 6	M Total number of transaction sets included in the functional group or interchange (transmission) group terminated by the trailer containing this data element.
GE02	0028 Group Control Number
N0 1 9	M Assigned number originated and maintained by the sender. The Group Control Number, GE02, must be identical to the one found in the associated functional header GS06.

X12 Segment Name: IEA Interchange Control Trailer
Loop: ----
Max. Use: 1
X12 Purpose: To define the end of an interchange of zero or more functional groups and interchange-related control segments
Usage: Mandatory
Example: IEA*1*000000912~

Element Attributes	Data Element Usage
IEA01 I16	Number of Included Functional Groups N0 1 5 M A count of the number of functional groups included in an interchange
IEA02 I12	Interchange Control Number N0 9 9 M A control number assigned by the interchange sender The Interchange Control Number, IEA02, must be identical to the one found in the associated Interchange Header ISA13.